REGISTRATION AND TREATMENT

Date_____

Home Phone (_____)_____

Cell Phone (_____)_____

PATIENT INFORMATION

Name_____ SS/HIC/Patient ID #_____
Last Name First Name Middle Initial

Address_____ E-mail_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Employer/School Phone (_____)_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone (_____)_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Middle Initial

Relation to Patient_____ Birthdate_____ ID#/Soc. Sec. #_____

Address (if different from patient's)_____ Phone (_____)_____

City_____ State_____ Zip_____

Person Responsible Employed By_____ Occupation_____

Business Address_____ Business Phone (_____)_____

Employer/School Address_____

Contact #_____ Group #_____ Subscriber #_____

Names of other dependants covered under this plan_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address (if different from patient's)_____ Phone (_____)_____

City_____ State_____ Zip_____

Subscriber Employed by_____ Business Phone (_____)_____

Insurance Company_____ Soc. Sec. #_____

Contact #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan_____

Please Complete Above Information and Next Page

DENTAL HISTORY

Reason for Today's Visit_____ Date of last dental care_____

Former Dentist_____ Date of last dental X-rays_____

Address_____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit_____

Have you had any serious illnesses or operations? ☐ Yes ☐ No if yes, describe_____

Have you ever had a blood trtransfusion? ☐ Yes ☐ No if yes, give approximate dates_____

Have you ever taken any of the group of drugs collectively reffered to as "fen-phen"? These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circularoty Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS
List medications you are currently taking:

ALLERGIES

AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and consent their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.