McKnight Family Dental

Adult Registration **Today's Date:**

PATIENT INFORMATION			
Patient's Last name:	First:	Middle:	
Marital Status: Single Married Divorced Widowed Separated			
Former Name:	Birth date:	Age:	Sex: F M
Street address:		Social Security #:	
City:	State:	Zip Code:	Home Phone #: ( )
Work Phone #: ( )	Cell Phone #: ( )	Primary Phone: Home Work Cell	
Occupation:	Employer:	Employer Phone #: ( )	
Spouse's Name:	Occupation:	Employer:	Employer Phone #: ( )
Referred to clinic by (Please Circle One): Insurance Near Home/Work Phone Book Family/Friend: Other:			
Other Family Members Seen Here:	email:		
DENTAL INSURANCE INFORMATION			
Policy Holder's Information: **Name**:	**Birth Date**:	**Social Security #:**	
Address (If Different):	City	State	Zip Code
Dental Insurance Company:	Policy #:	Group #:	
Medicaid (11 Digit ID #):	*Medicaid Card Must Be Presented At Time Of Service		
Patient's Relationship to Policy Holder: Self Spouse Child Other:			
HEALTH HISTORY			
Purpose Of This Appointment:			
Date of Last Dental Care:	For What?		
Date of Last Medical Care:	Physician:		
Have You Been Hospitalized in the Last 5 Years: Yes No For What?			
List **Any** Medical Problems Or Physical Conditions We Should Be Aware of:			
Women: Are You Pregnant or Think You May Be? Yes No			
Do You Now, or Have You Ever Had: Anemia Diabetes Venereal Disease Hepatitis Abnormal Heart Condition Rheumatic Fever Epilepsy HIV Any Infectious Disease High Blood Pressure Other:			
Joint Replacement: Yes No Date of Replacement: Joints Replaced:			
Do You Have Allergies to: Penicillin Local Anesthetic Latex Sulfa Nickel Other: None			
Are You Currently On Blood Thinners: Yes No List all Medications Currently Taking:			
Do you smoke? Yes No Smokeless Tobacco Yes No History of Substance Abuse Yes No			
IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Phone #: ( )	
PLEASE READ & SIGN BELOW			
****I understand that I am responsible for any amount not covered by the insurance company and a 1.33% per month finance charge (16% annually) will be added to my account for balances over 90 days.**			

Patient/Guardian Signature: Date: