

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE				1
NAME				
SPOUSE				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE				
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWDED	
SOCIAL SECURITY NO				
DATE				
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL				
GRADE				
SOCIAL SECURITY NO				
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO				

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DENTAL INSURANCE		2
<i>PRIMARY CARRIER</i>		
INSURANCE COMPANY		
GROUP NO		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO		
EMPLOYEE NO		
EMPLOYEE SOCIAL SECURITY NO		
<i>SECONDARY CARRIER</i>		
INSURANCE COMPANY		
GROUP NO		
EMPLOYEE NO		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO		
EMPLOYEE NO		
EMPLOYEE SOCIAL SECURITY NO		

ACCOUNT INFORMATION 4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME	
RELATIONSHIP TO PATIENT	
ADDRESS	
CITY	STATE ZIP
PHONE NO	
YOU	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE	EXT.
YOUR SPOUSE	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE	EXT.

GETTING TO KNOW YOU 3

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	RELATIONSHIP:
REFERRED TO US BY	
YOUR FORMER ADDRESS	
CITY/STATE/ZIP	
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CITY/STATE/ZIP	
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY/STATE/ZIP	

1. Are you having pain or discomfort at this time?..... YES NO
2. Have you been a patient in the hospital during the past two years?..... YES NO
3. Have you been under the care of a medical doctor during the past two years?..... YES NO
 Physician's Name _____ Phone No. _____
 Address _____
4. Have you taken any medication or drugs during the past two years?..... YES NO
5. Are you now taking any medication, drugs, or pills?..... YES NO
 If yes, please list: _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?..... YES NO
 If yes, please list: _____

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure.....	YES NO	Artificial Joints (hip, knee, etc.).....	YES NO	Hepatitis B (serum).....	YES NO
Heart Disease or Attack.....	YES NO	Kidney Trouble.....	YES NO	Venereal Disease.....	YES NO
Angina Pectoris.....	YES NO	Ulcers.....	YES NO	A.I.D.S.	YES NO
Congenital Heart Disease.....	YES NO	Diabetes	YES NO	H.I.V. Positive.....	YES NO
Heart Murmur.....	YES NO	Thyroid Problems.....	YES NO	Cold Sores/Fever Blisters.....	YES NO
High Blood Pressure.....	YES NO	Glaucoma.....	YES NO	Blood Transfusion.....	YES NO
Arteriosclerosis.....	YES NO	Cosmetic Surgery.....	YES NO	Hemophilia.....	YES NO
Mitral Valve Prolapse.....	YES NO	Emphysema.....	YES NO	Anemia.....	YES NO
Artificial Heart Valve.....	YES NO	Chronic Cough.....	YES NO	Sickle Cell Disease.....	YES NO
Heart Pacemaker.....	YES NO	Tuberculosis.....	YES NO	Bruise Easily.....	YES NO
Heart Surgery.....	YES NO	Asthma.....	YES NO	Liver Disease.....	YES NO
Rheumatic Fever.....	YES NO	Hay Fever.....	YES NO	Yellow Jaundice.....	YES NO
Arthritis.....	YES NO	Allergies or Hives.....	YES NO	Epilepsy or Seizures.....	YES NO
Rheumatism.....	YES NO	Sinus Trouble.....	YES NO	Fainting or Dizzy Spells.....	YES NO
Cortisone Medicine.....	YES NO	Radiation Therapy.....	YES NO	Nervousness.....	YES NO
Drug Addiction.....	YES NO	Chemotherapy.....	YES NO	Psychiatric Treatment.....	YES NO
Stroke.....	YES NO	Hepatitis A (infectious).....	YES NO	Developmentally Disabled.....	YES NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?..... YES NO
9. Do your ankles swell during the day?..... YES NO
10. Do you use more than two pillow to sleep?..... YES NO
11. Have you lost or gained more than 10 pounds in the past year?..... YES NO
12. Do you ever wake up from sleep and feel short of breath?..... YES NO
13. Are you on a special diet?..... YES NO
14. Has your medical doctor ever said you have a cancer or tumor?..... YES NO
15. Do you have or have you had any disease, condition, or problem not listed?..... YES NO
 If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ___ Yes, what month? ___ ___ No Are you nursing? ___ Yes ___ No Are you taking birth control pills? ___ Yes ___ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of services and rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____