

PATIENT REGISTRATION AND MEDICAL HISTORY
(PLEASE PRINT)

Date _____ Home Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Email Address _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse Name _____ Spouse Birthdate _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Who may we thank for referring you to our office? _____

INSURANCE

Do you have insurance coverage? Yes No

Plan Name _____ Group # _____

Phone No _____ Policy # _____

Address _____ City _____ State _____ Zip _____

RELEASE AND ASSIGNMENT

I certify that I am covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I am also responsible for any and all charges incurred for collection services.

Signature _____ Date _____

In the event, I fail to pay my balance within 90 days from date of service I agree to pay all costs of collection, including attorney fees.

Signature _____ Date _____

MEDICAL HISTORY

Physician's Name _____ Date of last physical _____

Have you ever had any of the following? (Check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> AIDS or Other Immunosuppressive Disorders |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Allergies to Medicine or Drugs | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Arthritis |

Have you ever been tested for HIV? _____ Positive Negative

Do you have any drug allergies or have you ever had adverse reaction to any medication? Yes No if so, please describe _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? Yes No if so, please describe _____

Are you under the care of a physician? Yes No For what condition? _____

(Woman) Do you suspect that you are pregnant? Yes No Are you nursing? Yes No

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature _____ Date _____

UPDATE (To be completed at a later visit)

Have there been any changes in the patient's health since last dental appointment? Yes No

If so, please describe _____

Is the patient taking any new medications? _____ if so, please list _____

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____