



PATIENT REGISTRATION FORM

PATIENT NAME: _____ Male Female
Address: _____ City: _____ State: ____ Zip: _____
Telephone: Home: _____ Cell: _____ Work: _____
Birth date: _____ Age: ____ Social Security #: _____ Driver's License #: _____
Single Married Divorced Minor Email: _____
Are you employed? No Yes - Employer's Name: _____
Employer's Address: _____
Spouse/Parent's Name: _____ Spouse/Parent's Phone: _____
Emergency Contact Person: _____ Phone: _____ Relationship: _____

REFERRING DOCTOR

Ref Doctor's Name: _____
Ref Doctor's Address: _____ City: _____ State: ____ Zip: _____
Ref Doctor's Phone: _____ Fax: _____
Ref Doctor's Name: _____
Ref Doctor's Address: _____ City: _____ State: ____ Zip: _____
Ref Doctor's Phone: _____ Fax: _____

INSURANCE INFORMATION

Who is responsible for this account? Patient Other
Dental Insurance Coverage
Insurance Carrier: _____ ID#: _____ Group #: _____
Insured's Name: _____ Insured's DOB: _____ Insured's SS#: _____
Medical - Primary Insurance Coverage
Insurance Carrier: _____ ID#: _____ Group #: _____
Insured's Name: _____ Insured's DOB: _____ Insured's SS#: _____
Secondary Insurance Coverage - Dental Medical
Insurance Carrier: _____ ID#: _____ Group #: _____
Insured's Name: _____ Insured's DOB: _____ Insured's SS#: _____

We will submit billing to your primary and secondary insurance carrier. To do this, we must have complete information and a copy of your insurance cards. If you are not covered by insurance, we ask that you pay for the office visit today and make arrangements for the remaining balance.

I hereby authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

I also authorize payment to be made directly to the physician or to myself in the event the physician is not participating with the payer. I understand I am financially responsible to the physician for all charges.

I hereby acknowledge that I have reviewed the practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding the Notice

Patient/Guardian's Signature _____ Date _____

Name: _____

MEDICAL HISTORY: Please answer all questions by circling yes (Y) or no (N)

All answers are kept confidential

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|--|-----|--|-----|
| 1. Are you in good health? | Y N | 10. Are you using or taking any of the following? | |
| 2. Has there been any change in your general health in the past year? | Y N | A. Tagamet? | Y N |
| 3. Date of last physical exam: _____ | | B. Thyroid medications? | Y N |
| 4. Are you now under a physician's care for a particular problem? | Y N | C. Antibiotics or sulfa drugs? | Y N |
| If yes, for what? _____ | | D. Anticoagulants/blood thinners? | Y N |
| 5. Have you had any serious illnesses, operations or hospitalizations? | Y N | E. High blood pressure medicine? | Y N |
| If so, describe: _____ | | F. Steroids, cortisone, etc.? | Y N |
| 6. Have you had any adverse effects from dental treatment? | Y N | G. Osteoporosis medicine (fosomax, etc) | Y N |
| 7. Do you have or have you ever had any of the following: | | H. Insulin, diabinese, or similar drug? | Y N |
| A. Rheumatic fever or rheumatic heart disease? | Y N | I. Digitalis, inderal, nitroglycerin, calcium blockers, procardia or other heart medication? | Y N |
| B. Congenital heart disease? | Y N | J. Aspirin or ibuprofen (motrin, naprosyn, etc)? | Y N |
| C. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker installed)? | Y N | How much daily? _____ | |
| D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? | Y N | K. Antihistamines or other decongestants (seldane, etc)? | Y N |
| E. Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown? | Y N | L. Drug(s) to assist in weight loss or weight gain? | Y N |
| F. Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily? | Y N | M. Any other medications, pills or drugs, including "street drugs"? | Y N |
| G. Liver disease (jaundice, hepatitis)? | Y N | If yes, please specify: _____ | |
| H. Kidney disease? | Y N | 11. Are you allergic or have a bad reaction to: | |
| I. Diabetes? | Y N | A. Local anesthesia (novocaine, etc.)? | Y N |
| J. Thyroid disease? | Y N | B. Penicillin, amoxicillin, cephalosporins or other antibiotics? | Y N |
| K. Arthritis? | Y N | C. Barbiturates, sedatives, etc.? | Y N |
| L. Stomach ulcers or colitis? | Y N | D. Aspirin or ibuprofen? | Y N |
| M. Glaucoma? | Y N | E. Codeine or other pain killers? | Y N |
| N. Frequent or recurring mouth sores? | Y N | F. Latex or rubber products? | Y N |
| | | G. Other allergies or reactions? | Y N |
| O. Implants placed in your body (heart valve, hip, knee)? | Y N | If yes, please specify: _____ | |
| P. Radiation (x-ray) treatment for cancer? | Y N | 12. Do you use alcohol? How much? _____ | Y N |
| Q. Clicking or popping of jaw joint, pain near ears, difficulty in opening mouth, grinding or clenching your teeth? | Y N | 13. Have you ever sought professional care for drug abuse, alcoholism, or emotional disorders? | Y N |
| R. Sinus or nasal problems? | Y N | | |
| S. Any disease, drugs or transplant operation that may suppress your immune system? | Y N | 14. WOMEN: Are you pregnant or planning pregnancy? | Y N |
| T. Recurring infections of any kind? | Y N | A. Are you taking any birth control pills? | Y N |
| 8. Do you wear contact lenses? | Y N | B. Are you taking hormone replacements? | Y N |
| 9. Do you smoke or chew tobacco? How much daily? _____ | Y N | 15. Do you have any other disease, condition or problem that you think the doctor should know about? | Y N |

I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor and the information I have provided here is complete and accurate.

Patient/Guardian Signature _____ Date: _____

Physician's Signature _____ Date: _____