PATIENT REGISTRATION

PATIENT INFORMATION

Name_____Date of Birth_____SS#_____Age_____Sex_____

Address_____City/State/Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Email Address (we will **not** release to anyone else)_____**Please circle best way to contact.**

Employer and Location_____Occupation_____

Who may we call in case of emergency?_____Phone_____

Who may we thank for referring you?_____

INSURANCE INFORMATION

Name of Insured_____Date of Birth_____Relationship to Patient:_____

Address_____Phone Number_____SS#_____

Employer_____Work Phone_____

Dental Insurance Co_____Group #_____Phone Number_____

Person Responsible For Account_____Phone Number_____

DENTAL HISTORY

YES NO Do you have a specific dental problem?_____

YES NO Do you have routine dental examinations? Date of last dental visit?_____

YES NO Would you describe your current dental health as good?/Comments_____

YES NO Do you think you have decay or gum disease?_____

YES NO Do you gums bleed?/Explain_____

YES NO Are you nervous about having treatment done?_____

YES NO Do you want to keep your remaining teeth?_____

YES NO Do you like your smile?_____

YES NO Do you like the color of your teeth?_____

YES NO If you wear dentures, are you pleased with them? If not, please explain_____

MEDICAL HISTORY

Medical Drs Name_____Phone _____Office Location_____

Are you under Dr's care now? Explain_____

Have you been hospitalized? Why?_____

Are you taking any medications?/What?_____

Are you allergic to medications or substances?Which?_____

Are you pregnant? Expected due date?_____

Please Circle Any of the Following That Apply Now or in the Past

Heart Trouble	Stroke	Diabetes	Hypoglycemia	Ulcers
Heart Murmur	Artificial Hips or Joints	Epilepsy or Seizures	Arthritis	Tuberculosis
Artificial Heart Valve	Rheumatic Fever	Pain in Jaw Joints	Gout	Thyroid Disease
Heart Surgery	Cancer	Blood Disease	Cortisone Medications	Smoke
Pacemaker	Chemotherapy/Radiation	Hepatitis A, B, or C	Other Steroid Treatments	Chew Tobacco
Chest Pain	Asthma	Bruise Easily	Psychiatric Care	Osteoporosis Medicine
High Blood Pressure	Hay Fever or Sinus Trouble	Hemophilia	Drug Addiction	Allergies to Medicines
Low Blood Pressure	Allergies	Liver Disease	AIDS	Birth Control Pills

CONSENT

I (undersigned) hereby authorize 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. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated with(name of patient)_____and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. Insurance claims will be filed for me and my family only if proof of insurance coverage is provided. Estimates given for treatment are not guarantees of payment but only an estimation based on information provided by my insurance company.

I understand that patients are seen on an appointment basis and that a 24 hour notice is requested in the event I or family members are not able to keep an appointment.

SIGNATURE(RESPONSIBLE PARTY)_____DATE_____

Do you wish to talk to the Dr. privately?_____

OFFICE USE ONLY

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