

REGISTRATION FORM



Date:	Parent/Guardian:
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PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital status (circle one) Single / Married / Other	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:			Employer:		Employer phone no.: ()		
Email Address:				Mobile phone no.: ()			
How did you hear about us (please check one box):			<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Close to home/work		
<input type="checkbox"/> Family Member (name)		<input type="checkbox"/> Friend (name)		<input type="checkbox"/> Dr. Referral (name)			
Other family members seen here:							

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:		Address (if different):			Relationship:		
Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Birth date: / /		Home phone no.: ()			
Occupation:		Employer:		Employer address:			
Is this patient covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Employer phone no.: ()				
Primary Insurance Name and Address:					Group no.:		
Subscriber's name:			Birth date: / /		Subscriber's SSN or Insurance ID #:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Secondary Insurance Name (if applicable) and Address:					Group no.:		
Subscriber's name:			Subscriber Birth Date: / /		Subscriber SSN or Insurance ID#:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:		Home phone : ()		Work phone : ()	
Signature:				Relationship:			

HEALTH HISTORY INFORMATION



Answers to the following questions are for our records only and will be considered confidential.

Patient Name: _____

Date of last Physical Examination: _____ Physician's Name: _____

Date of last Dental Examination: _____ Date of last Dental X-Rays: _____

Previous Dentist's Name: _____ City / State: _____

CIRCLE THE APPROPRIATE ANSWER

Are you having any pain or discomfort at this time?	YES	NO	Do you feel nervous about having dental treatment?	YES	NO
Have you ever had a bad experience in a dental office?	YES	NO	Is there anything you dislike about your smile?	YES	NO
Is there anything you would like to discuss with the Doctor in private?	YES	NO	Have you been a patient in the hospital during the past two years?	YES	NO
Have you been under the care of a medical doctor in the past two years?	YES	NO	Have you taken any medications or drugs in the past two years?	YES	NO
Are you taking any vitamins, herbal supplements or "cures" ?	YES	NO	Have you had any excessive bleeding requiring special treatment?	YES	NO

ALLERGIES AND MEDICATIONS

Do you have any allergies to medications, antibiotics or latex?	YES	NO	If YES, please list:
Are you currently taking any medications? (If you have a list we will gladly copy it.)	YES	NO	If YES, please list:

MEDICAL CONDITIONS Please select Yes or No to indicate if you have had any of the following:

Chest Pain	YES	NO	Shortness of Breath	YES	NO	Hives or Skin Rash	YES	NO
Heart Failure	YES	NO	Ulcers	YES	NO	Alcoholism	YES	NO
Heart Disease or Attack	YES	NO	Mental Retardation	YES	NO	Herpes	YES	NO
Angina Pectoris	YES	NO	Emphysema	YES	NO	Glaucoma	YES	NO
Heart Problems	YES	NO	Fainting or Dizzy Spells	YES	NO	*Steroid Treatment	YES	NO
Liver Disease	YES	NO	Eating Disorder	YES	NO	Arthritis	YES	NO
Heart Surgery	YES	NO	Epilepsy or Seizures	YES	NO	*Any type of Implant	YES	NO
High Blood Pressure	YES	NO	Persistent Cough	YES	NO	Dentures or Partials	YES	NO
*Heart Murmur	YES	NO	Tuberculosis (TB)	YES	NO	Birth Defects	YES	NO
*Rheumatic Fever	YES	NO	Asthma	YES	NO	HIV Positive, ARC, AIDS	YES	NO
Psychiatric Treatment	YES	NO	*Congenital Heart Problems	YES	NO	Hay Fever	YES	NO
Sickle Cell Disease	YES	NO	Hepatitis A (Infectious)	YES	NO	Use of tobacco product	YES	NO
Sinus Trouble	YES	NO	Hepatitis B (Serum)	YES	NO	Bruise Easily	YES	NO
*Artificial Joints	YES	NO	Hepatitis C or other	YES	NO	Jaundice	YES	NO
Thyroid Disease	YES	NO	Heart Pacemaker	YES	NO		YES	NO
Anemia	YES	NO	Stroke	YES	NO	Kidney Trouble	YES	NO
Blood Transfusion	YES	NO	Drug Addiction	YES	NO	Hemophilia	YES	NO
*Any type of Transplant	YES	NO	Cold Sores	YES	NO	Diabetes	YES	NO
*Mitral Valve Prolapse	YES	NO	Radiation Therapy	YES	NO	Chemotherapy	YES	NO
Cancer	YES	NO	Pregnant / Nursing	YES	NO	Osteoporosis	YES	NO

I certify that I have read and understand the above information and have answered accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to perform x-rays and other aids necessary for complete diagnosis of oral conditions. I authorize the dentist to perform any and all treatment, mutually agreed upon by me. I understand the use of anesthetic agents carries inherent risks. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance is a contract between me and the insurance carrier (not the Doctor) and that I am fully responsible for all fees incurred during my care in this office. I understand that fees are payable at the time services are rendered. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____	Date: _____
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's
Notice of Privacy Practices.

Printed Name: _____

Signature: _____ **Date:** _____

If this form is signed on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

You are entitled to a copy of this form after you sign it.