PATIENT REGISTRATION

Current Date: ______ / ______ / ______

Patient's Name: ____________________

Date of Birth: ______ / ______ / ______

____ - ____ - ____ Social Security Number ____ Drivers License Number ____ Issuing State

Sex of Patient: ☐ Male ☐ Female

Marital Status:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

If patient is a Minor:
Parent/Guardian's Name: ____________________

____ - ____ - ____ Social Security Number ____ Drivers License Number ____ Issuing State

Name by which you wish to be addressed: ____________________

Person who is responsible
for this account: ____________________

Method of Payment: ☐ Cash ☐ Check ☐ Credit Card

Patient Address:

____ Number ____ Street

____ City ____ State ____ Zip Code

Home Telephone #: ____________________

____ eMail address ____ Cell Phone / Pager Number

BUSINESS INFORMATION:

____ Name of Patient's Employer

____ Number ____ Street

____ City ____ State ____ Zip Code

Work Telephone #: ____________________

eMail address: ____________________

Present Position: ____________ Since: ____________

Purpose of visit: ____________________

Other family members in this practice: ____________________

Other than person's at your residence, who should we notify in case of emergency?:

Name: ____________________

Telephone #: ____________________

How did you hear about us?: ____________________

If personal reference, whom may we thank?:

____

Spouse or Responsible Party's Name (if applicable):

____

____ - ____ - ____ Social Security Number ____ Drivers License Number ____ Issuing State

____ Name of Responsible Party's or Spouse's Employer

____ Number ____ Street

____ City ____ State ____ Zip Code

Work Telephone #: ____________________

eMail address: ____________________

Present Position: ____________ Since: ____________

DENTAL INSURANCE - 1ST COVERAGE

Employee Name: ____________________

Employee Date of Birth: ______ / ______ / ______

Social Security # if responsible
party is not the Patient: ______ - ______ - ______

Employer: ____________ Since: ____________

Insurance Company:

____ Name

____ Number ____ Street

____ City ____ State ____ Zip Code

Telephone #: ____________________

Union Local or Group if applicable: ____________________

DENTAL INSURANCE - 2ND COVERAGE

Employee Name: ____________________

Employee Date of Birth: ______ / ______ / ______

Social Security # if responsible
party is not the Patient: ______ - ______ - ______

Employer: ____________ Since: ____________

Insurance Company:

____ Name

____ Number ____ Street

____ City ____ State ____ Zip Code

Telephone #: ____________________

Union Local or Group if applicable: ____________________

DENTAL / MEDICAL HISTORY

Approximate date of last dental visit: ______/______/______ Were X-Rays taken?: ______________
Previous dental problems that the dentist should know about?: ______________________________

____

Have you ever been advised that you have Periodontal or Gum disease?: ______________________

Name of previous:
Dentist: ______________________ Telephone #: ______________ eMail: ______________
Address: ______________________ City: ______________ State & Zip: ______________
Approximate date of last medical examination: ______/______/______
Name of physician: ______________________ Telephone #: ______________ eMail: ______________
Address: ______________________ City: ______________ State & Zip: ______________

DO YOU HAVE OR HAVE YOU EVER HAD?:

Rheumatic Fever ☐ Yes ☐ No   Hepatitis ☐ Yes ☐ No   Hip or Joint Surgery ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No   Heart Murmur ☐ Yes ☐ No   Venereal Disease ☐ Yes ☐ No
Anemia ☐ Yes ☐ No   Diabetes ☐ Yes ☐ No   Seizures ☐ Yes ☐ No
Abnormal Heart condition? ☐ Yes ☐ No   High Blood Pressure ☐ Yes ☐ No
If yes, please explain: ____

____

Have you ever taken diet medication: Phen/Phen, Redux? ☐ Yes ☐ No If other, what?: ______________
Allergies to: Codeine ☐ Yes ☐ No   Penicillin ☐ Yes ☐ No   Latex or Rubber Products ☐ Yes ☐ No
Other: (Please specify): ____

____

Have you ever tested positive for the AIDS virus (HIV)? ☐ Yes ☐ No

Have you had any major surgeries in the past five years? ☐ Yes ☐ No If yes, what?: ______________

____

Are you being treated by a physician now? ☐ Yes ☐ No If yes, for what?: ______________

____

Are you taking any medication now? ☐ Yes ☐ No If yes, what?: ______________

____

Have you ever been advised that you should be pre-medicated for any dental or surgical treatment? ☐ Yes ☐ No
If yes, with what? Antibiotics? ☐ (other): ______________________________

Do you have any physical condition or disease that the dentist should know about? ☐ Yes ☐ No

____

(For Female Patients) Are you pregnant? ☐ Yes ☐ No If yes, what is the due date?: ______/______/______

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize the release of any information concerning my (or my dependent's) health care, advice and treatment to another dentist.

I understand that I am responsible for all costs of dental treatment; and that I may be charged a fee of $25 to $50 for repeatedly missing appointments or short-notice cancellations (8 hours or less).

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that it is my responsibility to keep the information on this form current, by informing the dental office of any changes in address, phone numbers, employment and/or insurance carrier information. By not providing current insurance information to the dental office for maintenance in the Patient Registration records, I assume full liability for my account.

I attest to the accuracy of this form.

Patient's or Responsible Party's Signature: ______________________________ Date: ______/______/______

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