PATIENT REGISTRATION

Name _____Birthdate _____ Sex_____
Address _____ S.S.# _____ Home Phone _____
City _____State _____Zip_____
Patient's (or parents) Employer_____
Employer's Address _____Employer's Phone_____
Name of Spouse_____ Spouse's Employer_____
City _____ State _____ Zip _____
If patient is a student, name & address of school/college:
Name_____ City _____ State_____
PERSON TO CONTACT IN CASE OF EMERGENCY: _____
Relationship to Patient _____ Home Phone _____
Employer Name & Address _____Employer Phone _____
City _____ State _____ Zip _____
Whom may we thank for referring you?_____

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IT IS OUR OFFICE POLICY THAT ALL DENTAL BILLS BE PAID THE SAME DAY SERVICES ARE RENDERED. IF YOU HAVE INSURANCE DEDUCTIBLE & CO-PAY IS ALSO DUE THE SAME DAY.

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*** PERSON RESPONSIBLE FOR THIS ACCOUNT IF OTHER THAN SELF.**

Name _____Relationship to patient _____
Address _____Home Phone _____
City _____State _____ Zip _____
Employer _____Work Phone _____
City _____State _____ Zip _____
* PLEASE NOTE: OUR OFFICE POLICY FOR MINOR CHILDREN: PARENT THAT BRINGS CHILD IN FOR TREATMENT IS RESPONSIBLE FOR PAYMENT OF ANY RELATED CHARGES.

INSURANCE INFORMATION

Name of Insured_____Birthdate_____S.S.# _____
Name & Address of Employer_____
Name of Insurance Company _____Phone Number _____
Address of Insurance Company _____
Policy or Group or I.D.Number_____
Do you have more than one insurance company?_____ If so,
Who is the primary carrier? _____Birthdate _____SS#_____
Name of secondary insured_____S.S.# _____
Name & address of employer_____
Name of insurance company_____ Group Number_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental 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.

X_____

Signature of Patient (or Parent/Guardian if Minor) & Date

Patient Medical History

Physician or clinic name_____ Phone # address_____
Date of last medical examination & reason_____
1. Are you under medical treatment now? _____ If yes, give reason_____
2. Have you ever been hospitalized for any surgical operation or serious illness? _____ If yes, please give date & explanation_____
3. Do you use tobacco? _____ If yes, what kind? _____
4. Do you use alcohol, cocaine, or other recreational drugs? _____ If yes, which? _____
5. Are you allergic to or have you had any reactions to the following:

___Local anesthetics (novacaine)	___Sulfa drugs	___ Latex or vinyl
___Penicillin	___Artificial colors/preservatives	___Aspirin
___Other antibiotics_____	___Other_____	

6. Do you have or have you had any of the followings:

___AIDS or HIV infection	___Epilepsy/convulsion	___Bleeding Disorders
___Anemia	___Fainting	___Joint replacement or implant
___Asthma	___Hay fever/Allergies	___Kidney problems
___Cancer	___Heart attack	___Liver problems
___Cardiac pacemaker	___Heart murmur	___Prolonged bleeding after surgery
___Chest Pains	___Hepatitis	___Radiation therapy
___Diabetes	___Tuberculosis	___Rheumatic fever
___High/low blood pressure	___Thyroid	___Respiratory problems
___Heart troubles	___Heart disease	___Other_____
___Stroke	___Sexually Transmitted Disease(s)	

7. Are you taking any medication(s), including nonprescription medicine, at this time? ____ if yes, what kind(s) & reason(s): _____
8. Have you ever been told by your Physician to premedicate with an antibiotic before dental treatment? _____
9. Do you have a history of medical illness/depression? _____ If yes, any current medications, please list_____
10. Women only: Are you pregnant or think you may be pregnant? _____ Are you nursing? _____
11. If you are on a blood thinner, what was your INR level?_____& date_____

Patient Dental History

1. Date and reason of last dental visit? _____
2. Do your gums bleed while brushing or flossing? _____
3. Are your teeth sensitive to sweets? _____
4. Are your teeth sensitive to hot or cold temperatures? _____
5. Do you feel pain in any of your teeth? _____
6. Do you have any sores or lumps in or near the mouth? _____
7. Have you had any head, neck, or jaw injuries? _____
8. Do you have discomfort upon chewing? _____
9. Have you ever experienced any of the following problems in your jaw?
   Clicking, pain in the joint, ear, and side of the face? _____
   Difficulty in opening or closing? _____
   Do you have frequent headaches? _____
   Do you clench or grind your teeth? _____
10. Have you ever had any difficult extractions in the past? _____
11. Have you had any orthodontic work? _____
12. Have you ever had prolonged bleeding following extractions? _____
13. Have you ever had instructions on the correct method of brushing and flossing your teeth? _____

I have read the above information, and to the best of my knowledge, it is complete and correct.

_____ _____
Signature of Patient (or Parent if Minor) Date