Patient Registration and Medical History

(Please Print)

Date_____ Home Phone_____ Cell Phone_____ Email_____

Preferred method of contact? _____

Patient_____
Last Name First Name Middle Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Sex: ☐ M ☐ F Age_____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security # _____ Employed by_____ Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name_____ Spouse/Parent Birth date _____

Spouse/Parent Employed by _____ Occupation_____

Business Address _____ Business Phone_____

Who is responsible for this account? _____ Relationship to Patient_____

Spouse/Parent Social Security #_____

Name of Dental Insurance Company _____ Group Number_____

In case of emergency, who should be notified_____ Phone_____

Whom may we thank for referring you?_____

Medical History

Are you under the care of a physician? ☐ Yes ☐ No Physician's Name_____ Date of last physical_____

Have you ever had any of the following? (check boxes that apply)

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Nervous Problems
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Back Problems
- ☐ Epilepsy
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Circulatory Problems
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Special Diet
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Sinus Problems
- ☐ Immunosuppressive Disorders
- ☐ Recent Weight Loss
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Respiratory Disease
- ☐ Headaches
- ☐ Cancer
- ☐ Diabetes
- ☐ Stroke
- ☐ Ulcer
- ☐ Hemophilia
- ☐ Blood Disease
- ☐ Arthritis

Do you take a premedication for dental appointments? ☐ Yes ☐ No Why?_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what? _____

_____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what _____

For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible of any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

Assignment and Release

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date Signature

Minor/Child Consent

I, being the parent or guardian of _____ do hereby request and
Name of Minor/Child

Authorize the dental staff to perform necessary dental services for my child, including but not limited to radiographs, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date Signature

I ACKNOWLEDGE RECEIPT OF ATTACHED NOTICE OF PRIVACY PRACTICES (Located on clipboard)

_____ _____
Date Signature

Medical History Update

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

_____

_____ _____
Date Patient Signature

_____ _____
Date Dentist Signature

Medical History Update

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

_____

_____ _____
Date Patient Signature

_____ _____
Date Dentist Signature