PATIENT REGISTRATION

TODAY'S DATE:____________

PATIENT:____
Last Name First Name Middle Initial

HOW WOULD YOU LIKE OUR STAFF TO ADDRESS YOU?________________________

ADDRESS:____
Street City State Zip

HOME #:__________________ WORK #:_________________CELL#_________________

HOW DO YOU WISH TO BE CONTACTED?___________________

BIRTHDATE:_________SEX:____ MARITAL STATUS:______ EMAIL:_______________

EMPLOYER:________________________ OCCUPATION:__________________________

DENTAL INSURANCE INFORMATION

****Please present dental insurance card for duplication****

****Claims cannot be filed if this section is not filled out completely****

EMPLOYEE NAME_____________________________ EMPLOYER__________________

INSURANCE COMPANY________________________ GROUP #_____________________

EMPLOYEE ID#______________________ EMPLOYEE BIRTHDATE________________

RELATIONSHIP TO PATIENT_________________ EMPLOYEE SS #:______________

IS PATIENT A FULL TIME STUDENT?_____ SCHOOL______________________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME____ SS#______________________
Last First Middle

ADDRESS____

EMPLOYER_________________ WORK #______________ CELL #__________________

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY, OR RELATIVE A PATIENT IN OUR OFFICE?_____ THEIR NAME____

EMERGENCY CONTACT________________________________ PHONE________________

ADDRESS____

HEALTH HISTORY

1) Are you having pain or discomfort at this time? Yes No
2) Do you feel very nervous about having dental treatment? Yes No
3) Have you ever had a bad experience in the dental office? Yes No
4) Have you been under the care of a physician during the past 2 years? Yes No
   Physician's Name____________________________________
   Address____

5) Are you currently taking any medication, drugs, or pills? Yes No
   If yes, please list:____________________________________
   ____

6) Are you allergic to any medications or substances? Yes No
   If yes, please list:____________________________________
   ____

Circle any of the following which you have had or have at present:

AIDS	Pacemaker	Sinus Trouble
Hepatitis (A, B, C)	Congestive Heart Failure	Fever Blisters
Diabetes	Heart Attack	Radiation Therapy
Heart Murmur	Heart Surgery	Hemophilia
Joint Replacement	Epilepsy	Drug Addiction
Asthma	Seizures	Venereal Disease
Tuberculosis	Arthritis	Psychiatric Treatment
Cancer	Stroke	Cosmetic Surgery
Heart Failure	Thyroid Disease	Pain in Jaw
Angina		

For women only:
Are you pregnant? ____ If yes, what month?__________

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 for any errors or omissions that I may have made in the completion of this form. I understand my signature will be used as a "signature on file" for insurance processing. 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. I further agree that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

****There will be a $25 charge for all appointments cancelled without 24 hours notice****

The undersigned hereby authorizes 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 in connection with (Name of Patient)_______________________.

Patient, Parent, or Responsible Party___________________________________ Date__________

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

Patient, Parent, or Responsible Party___________________________________ Date_________