Janis Moriarty, DMD, PC
REGISTRATION FORM

We are pleased to welcome you to our practice. Please print this form and take a few minutes to fill it out completely and take it with you to your appointment. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____ Home Phone _____ Cell Phone _____

Name _____ S.S. #_____
Last Name First Name Middle Initial

Address _____
Street, City, State & Zip

E-mail Address: _____

Sex: M ____ F ____ Birthdate _____ ____ Married ____ Single
____ Widowed ____ Minor
____ Separated ____ Divorced

Are you a full time student? _____

Patient Employer/School _____ Occupation _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ S.S # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Subscriber/ID# _____ Group # _____

Names of other dependents covered under this plan _____

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional Insurance? ___ YES ___ NO

Subscriber Name _____ Birthdate _____ Relationship _____

Phone _____ Subscriber Employed by _____

Insurance Company _____

Subscriber/ID # _____ Group # _____ S.S.# _____

Names of other dependents covered under this plan _____

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____ Phone _____

Check if you have had problems with any of the following:

___ Bad breath	___ Grinding teeth	___ Sensitivity to hot
___ Bleeding gums	___ Loose teeth or broken fillings	___ Sensitivity to sweets
___ Clicking or popping jaw	___ Periodontal treatment	___ Sensitivity when biting
___ Food collection between teeth	___ Sensitivity to cold	___ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).
___ YES ___ NO

Have you had any serious illnesses or operations? ___ YES ___ NO If yes, describe _____

Have you ever had a blood transfusion? ___ YES ___ NO If yes, give approximate dates _____

(Women) Are you pregnant? ___YES ___NO Nursing? ___YES ___NO

Taking birth control pills? ___YES ___NO

Check if you have or have had any of the following:

___ Anemia	___ Cortisone Treatments	___ Hepatitis
___ Arthritis, Rheumatism	___ Cough, Persistent	___ High Blood Pressure
___ Artificial Heart Valves	___ Diabetes	___ HIV/AIDS
___ Artificial Joints	___ Epilepsy	___ Jaw Pain
___ Asthma	___ Fainting	___ Kidney Disease
___ Back Problems	___ Glaucoma	___ Liver Disease
___ Blood Disease	___ Headaches	___ Mitral Valve Prolapse

___ Cancer	___ Heart Murmur	___ Pacemaker
___ Chemical Dependency	___ Heart Problems	___ Radiation Treatment
___ Chemotherapy	___ Hemophilia	___ Respiratory Disease
___ Circulatory Problems	___ Cough up blood	___ Rheumatic Fever
___ Scarlet Fever	___ Shortness of breath	___ Skin Rash
___ Stroke	___ Swelling of Feet or Ankles	___ Thyroid Problems
___ Tobacco Habit	___ Tonsillitis	___ Tuberculosis
___ Ulcer	___ Venereal Disease	

MEDICATIONS
List medications you are currently taking including over the counter medication(s):

_____

_____

ALLERGIES
_____

_____

AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Janis Moriarty, DMD, PC all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may discuss such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Date

Payment is due in full at time of treatment unless prior arrangements have been approved.