

# **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 \_\_\_  
Partnered for \_\_\_ years

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 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 INSURANCE**

Is patient covered by additional Insurance? \_\_\_ YES \_\_\_ NO

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Subscriber Employed by \_\_\_\_\_

Business Phone \_\_\_\_\_ Insurance Company \_\_\_\_\_

Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

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 \_\_\_\_\_

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> HIV/AIDS              |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Jaw Pain              |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Liver Disease         |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Pacemaker             |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems             | <input type="checkbox"/> Radiation Treatment   |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Hemophilia                 | <input type="checkbox"/> Respiratory Disease   |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Cough up blood             | <input type="checkbox"/> Rheumatic Fever       |
| <input type="checkbox"/> Scarlet Fever           | <input type="checkbox"/> Shortness of breath        | <input type="checkbox"/> Skin Rash             |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Swelling of Feet or Ankles | <input type="checkbox"/> Thyroid Problems      |
| <input type="checkbox"/> Tobacco Habit           | <input type="checkbox"/> Tonsillitis                | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> Venereal Disease           |  |

**MEDICATIONS**

List medications you are currently taking:

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**ALLERGIES**

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**AUTHORIZATION**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
Name of Insurance Company(ies)  
and assign directly to Dr. \_\_\_\_\_ 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.***