PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT) Home Phone (_____) _____

Patient_____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City_____ State _____ Zip _____

E-mail _____ Cell Phone (_____) _____

Sex ☐ M ☐ F Age _____ Birthday _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Social Security # _____ ☐ Separated ☐ Divorced ☐ Partner

Employer_____ Occupation _____

Employer/School address _____ Employer/School Phone (_____)_____

Parent/Guardian's Name (for minors) _____

Insurance Provider _____ Group Number _____

Insured Employer _____ Phone (_____)_____

Insured Name _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent

Insured Social Security # _____ Insured Birthday _____

In case of emergency, who should be notified? _____ Phone (_____)_____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

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

___ Allergies
___ Arthritis
___ Artificial Heart Valves or Joints, Screws, etc.
___ Back Problems
___ Bleeding Abnormally
___ Blood Disease
___ Cancer
___ Chemical dependency
___ Cholesterol
___ Chronic Diarrhea
___ Circulatory Problems
___ Congenital Heart Lesions
___ Diabetes
___ Epilepsy
___ Headaches
___ Heart Murmur
___ Heart Problems
___ Hemophilia
___ Hepatitis, Jaundice or Liver Disease
___ Hernia Repair
___ High Blood Pressure
___ HIV/AIDS
___ Low Blood Pressure
___ Mitral Valve Prolapse
___ Nervous Problems
___ Osteoporosis
___ Pacemaker
___ Psychiatric Care
___ Radiation Treatment
___ Recent Weight Loss
___ Respiratory Disease
___ Rheumatic Fever
___ Sinus Problems
___ Special Diet
___ Stroke
___ Swollen Neck Glands
___ Thyroids
___ Ulcer
___ Venereal Disease

Are you under the care of a physician? ☐ Yes ☐ No For what conditions ? _____

List any medications you are taking _____

Have you ever taken any of this group of drugs collectively referred to as "fen-phen?" This include combinations of Bisphosphonate, Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? Yes No

List Allergies _____

Have you ever responded adversely to medical or dental treatment? Yes No

(Women) Do you suspect that you are pregnant ☐ Yes ☐ No Due date _____

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

_____

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that is my responsibility to inform my doctor if y minor child ever has a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor / Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is covered by insurance 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 doctor may use my minor / child's health care information and my disclose 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 the current treatment plan is completed or one year from the date signed below.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor / child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Please print name of parent, Guardian or Personal Representative Date

MEDICAL HISTORY

_____ _____
Date Patient Signature

_____ _____
Date Dentist Signature

MEDICAL HISTORY UPDATED

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Is the patient taking any new medications? _____ -If so, what? _____

_____ _____
Date Patient Signature

_____ _____
Date Dentist Signature