

MEDICAL HISTORY / REGISTRATION

First Name: _____ Last Name: _____ (Mr., Mrs., Ms., Miss., Dr.)

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Date of Birth: _____ Male: _____ Female: _____

Marital Status: Married _____ Single _____ Divorced _____ Other _____ Email: _____

Who in your family should the bill be sent to: _____

What is the best way to reach you? _____

DENTAL INSURANCE INFORMATION

Employer or Company Name: _____ Employer/Company Phone: _____

Subscriber's Name: _____ Social Security #: _____ Date of Birth: _____

Insurance Company Name: _____ Insurance Phone: _____

ID #: _____ Group Name: _____ Group #: _____

Do you have a secondary dental insurance policy? Yes No

CHECK ALL THAT APPLY

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Rheumatic Fever or Rheumatic Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chemotherapy for Cancer | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Heart Murmur, Congenital Heart Disease, or Cardiac Stents | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> X-Ray Treatment for Cancer | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> AIDS or Positive HIV | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Asthma | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Addicted to Drugs or Alcohol | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bruises Easily |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hearing or Visual Problems | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Allergies or Hives |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Are You Taking Medicine? |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Are you allergic to Medications? |
| <input type="checkbox"/> Artificial Bone or Joints, AV Shunt | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Are you pregnant now? |
| | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cold Sores | |
| | | <input type="checkbox"/> Epilepsy or Seizures | |

- | | | |
|--|------------------------------|-----------------------------|
| 1. Do you feel very nervous about having dental treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you ever had a bad experience in the dental office | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you been hospitalized in the past two years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you ever had any excessive bleeding requiring special treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you feel very tired? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Do your ankles swell during the day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Do you use more than two pillows to sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Have you lost or gained more than 10 pounds in the past year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Do you ever wake up from sleep short of breath? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Are you on a special diet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Has your medical doctor ever said you have cancer or a tumor? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Do you smoke or chew tobacco? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Do you drink alcohol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Are you taking birth control? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Do you have and disease, condition, or problems not listed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, please list them: _____

MEDICAL HISTORY / REGISTRATION (continued)

Please list any medications you are taking:

Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by any of the following:

Novocain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Penicillin or other antibiotics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Codeine or other narcotics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other?	<input type="checkbox"/> Yes	<input type="checkbox"/> No - IF YES, please list: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient Signature: _____ Date: _____

Parent or Responsible Party: _____ Relationship: _____

CONSENT:

1. I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my/ dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and doctor, and to the appropriate medication and therapy indicated for such treatment in connection with:
(print name of patient) _____
I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that insurance is submitted as a courtesy and that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½ finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.

Patient Signature: _____ Date: _____

Parent or Responsible Party: _____ Relationship: _____

FOR OFFICE USE:

Reviewed by Dr. _____ Date: _____

ASA I II III IV