PATIENT REGISTRATION FORM

Patient's Name _____ Home Phone (___)_____ Cell Phone (___)_____
Date of Birth ___/___/___ Sex: M ___ F___ Single_____ Married _____ Name of Spouse _____
Address _____ P.O. Box _____City _____ State_____ Zip Code _____
Social Security No. _____ Employer _____ Business Phone ( ) _____
In emergency, please contact _____ Relationship _____ Phone (_____) _____
How did you hear about our office? _____
IF PATIENT IS A CHILD: Responsible Parent's Name _____ Address _____
Phone (___)_____ Social Security No. _____ Birth Date _____

DENTAL INSURANCE INFORMATION

Subscriber Name _____ S.S. #_____ Relationship to Patient _____
Subscriber Date of Birth ___/___/___ Group Number _____ ID Number _____
Employer Name_____ Insurance Company Name _____

SECONDARY DENTAL INSURANCE

Subscriber Name _____ S.S. # _____Relationship to Patient _____
Subscriber Date of Birth ___/___/___ Group Number _____ ID Number _____
Employer Name _____ Insurance Company Address _____

MEDICAL HISTORY

1. Are you currently under the care of a physician?_____Yes_____ No If so, what is the condition being treated?
   _____
2. Physician's Name & Address _____
3. Have you had any serious illness, operation, or been hospitalized? _____
   If so, explain _____
4. Are you taking any medicine(s) including any kind of blood thinner, non-prescription medicine, illegal or recreational drugs? If so, what medicine are you taking? _____
5. Please check if you are allergic or have you had a reaction to:
   _____ Local anesthetics _____ Aspirin _____ Metal sensitivity (jewelry, etc.)
   _____ Penicillin or other antibiotics _____ Latex _____ Barbituates, sedatives, or sleeping pills
   _____ Codeine or other narcotics _____ Sulfur _____ None (no known allergies)
   _____ Other _____
6. Please check if you have or have had any of the following diseases or problems: _____ Artificial Joint Prosthesis
   _____ Artificial Heart Valve _____ Seizures _____ AIDS or HIV Infection
   _____ Heart Murmur _____ Diabetes _____ Emphysema, Bronchitis, Asthma
   _____ Rheumatic Heart Disease _____ Hepatitis _____ Tuberculosis
   _____ Heart Trouble _____ Kidney Trouble _____ Stomach Ulcer or Hyperacidity
   _____ High Blood Pressure _____ Thyroid Problems _____ Mental Health
   _____ Stroke _____ Arthritis _____ Cancer and/or Chemotherapy
7. Have you had abnormal bleeding?_____ Yes_____ No Blood transfusion?_____Yes_____No
8. Have you had any serious trouble associated with any previous dental treatment? _____ Yes_____No
   If so, explain: _____
9. Do you have any disease, condition, or problem not listed above that you think we should know about?_____

WOMEN

Are you pregnant? ____Yes ___ No Are you nursing?____ Yes___ No Are you taking birth control pills?____Yes____No

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. AUTHORIZATION AND RELEASE: I authorize my insurance company to pay benefits to the dentist, and authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges, and if my payments are not received within 30 days of their due date, I agree to pay all costs of collections, including, but not limited to, reasonable attorney's fees.

Signature _____ Date _____