# REGISTRATION

Patient # ______________ Date ______________

Patient Name ______________ SS# ______________ Marital Status ______

DL# ______________ Home Phone ______________ Age ______ DOB ______

Address ______________ City ______________ State ______ Zip ______

In case of emergency, contact who? ______________ Phone ______________

Please list closest relative not living with you ______________ Phone ______________

Is there another member of your family that has been seen in our office? ______ Who? ______________

### POLICY ON PAYMENT FOR DENTAL TREATMENT PERFORMED

Patients that do not have dental insurance, should be prepared to pay for treatment the day that it is performed.

Patients that do have dental insurance should be prepared to pay the deductible part of the insurance, along with the estimated "copayment" part of the treatment on the day the treatment is performed.

### DENTAL INSURANCE INFORMATION

Do you have dental insurance? ☐ yes ☐ no

Insured's Name ______________

Insurance Company ______________

Insurance Co. Address ______________

Insurance Co. Phone# ______________

## BUSINESS INFORMATION

Person responsible for the account ______________ SS# ______________

Address ______________ City ______________ State ______ Zip ______

Phone ______________ Relation to Patient ______________ DOB ______________

Employer ______________ Employer Address ______________

City ______________ Phone ______________ How long there? ______

Latex Allergy ____ Yes ____ No

## DENTAL & MEDICAL HISTORY

It is important that I know your Medical and Dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone. Thank you for completely filling out this questionnaire.

### DENTAL HISTORY

Do your gums bleed when you brush? ______________

How often do you floss? ______________

Have you been satisfied with your previous dental care?

______________

Please list reason for this visit ______________

______________

### MEDICAL HISTORY

Do you havey any CURRENT health problems? ______________

Are you under a PHYSICIANS CARE now? ______________

If so, for what? ______________

Are you currently taking any medication? ______________

If yes, what? ______________

Are you pregnant? ☐Yes ☐No If yes, what month? ______

## Circle any of the following which you have had or have at the present time

| | | | | |
|---|---|---|---|---|
| Heart Failure | Congenital Heart Lesions | Diabetes | Liver Disease | Nervousness |
| Mitral Valve Prolapse | Heart Surgery | Bleeding Problems | Rheumatism | Arthritis |
| Artificial Heart Valve | High Blood Pressure | A.I.D.S. | Chemotherapy | Hay Fever |
| Heart Murmur | Epilepsy or Seizures | Hemophilia | Kidney trouble | Fever Blisters |
| Heart Disease or Attack | Tuberculosis (TB) | Hepatitis A (infectious) | Yellow Jaundice | Psychiatric treatment |
| Rheumatic Fever | Anemia | Blood transfusion | Venereal Disease | Cortisone medication |
| Heart Pacemaker | Hepatitis B (serum) | Sickle Cell Disease | Scarlet Fever | Bruise easily |
| Stroke | Drug addiction | Thyroid Disease | Ulcers | Sinus trouble |
| Artificial Joints | X-ray or Cobalt Treatment | Glaucoma | Fainting or dizzy spells | Pain in jawpoints |
| Angina | Alcoholism | Asthma | Cosmetic surgery | Allergies or hives |

**Do you have any allergies? ☐ Yes ☐ No If so please list** ______________

CONSENT: The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (Parent or Guardian for minors) ______________ Date ______________