

PATIENT REGISTRATION AND HISTORY

DATE		NAME		
ADDRESS		CITY	STATE	
ZIP	HOME PHONE NO.	BIRTHDATE		
SINGLE	MARRIED	DIVORCED	WIDOWED	SOCIAL SECURITY NO.
OCCUPATION		EMPLOYER		
BUSINESS ADDRESS (City)		BUSINESS PHONE		
EMAIL ADDRESS				
SPOUSE'S NAME		OCCUPATION		
EMPLOYER		BUSINESS PHONE		

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?: _____

IF APPOINTMENT IS FOR A CHILD

DATE		NAME	
ADDRESS		CITY	STATE
ZIP	HOME PHONE NO.	BIRTHDATE	
AGE	GRADE	SOCIAL SECURITY NO.	
SCHOOL			

ACCOUNT INFORMATION (Person financially responsible for account or check here if same as above)

NAME		ADDRESS	
CITY	STATE	ZIP	HOME PHONE NO.
BUSINESS ADDRESS (City)		BUSINESS PHONE	

1. Are you having pain or discomfort at this time?.....YES NO
2. Do you feel very nervous about having dental treatment?YES NO
3. Have you ever had a bad experience in a dental office?YES NO
4. When was your last dental visit? _____
5. Have you been a patient in the hospital during the past two years?.....YES NO
6. Have you been under the care of a medical doctor during the past two years?.....YES NO

Your physician's name _____

Address _____

Phone _____

7. Have you taken any medicine or drugs during the past two years?YES NO

If yes, please list _____

8. Are you allergic to or had problems taking any of the following medications?

Aspirin Nitrous Oxide Valium Local Anesthetic

Penicillin Erythromycin Tetracycline Codeine

Other antibiotics Other _____ 9. Do you now have or have you ever had any of the following?

- Heart Failure
- Heart Attack
- Angina
- Liver disease
- Allergies
- Artificial heart valve
- Radiation treatment
- Epilepsy
- Anemia
- Psychiatric treatment
- Ulcer
- Emphysema
- Prolonged coughs
- Tuberculosis
- Heart Murmur
- Drug addiction
- Thyroid disease
- Cold sores
- Cancer
- Fainting
- Kidney disease
- Cosmetic surgery
- HIV/AIDS
- Hepatitis A
- High Blood Pressure
- Yellow Jaundice
- Diabetes
- Venereal disease
- Chemotherapy
- Artificial joints
- Stroke
- Glaucoma

10. When you walk up stairs, do you ever have to stop because of pain in your chest? YES NO

11. Have you lost or gained more than ten pounds during the past year? YES NO

12. Are you on a special diet?YES NO
13. Do you have any disease or condition not listed? YES NO
14. Are you pregnant or nursing?YES NO

**IMPORTANT INFORMATION
PLEASE READ CAREFULLY!**

CONSENT OF PAYMENT

As a courtesy to our patients, our staff will gladly file your insurance. Insurance carriers sometimes deny payment of a claim. This form serves to inform you if your insurance denies your claim; you are responsible for the charges.

Our staff will make every attempt to assist you in finding answers to your insurance questions. Unfortunately, we cannot guarantee payment or coverage on any services, as this is solely determined by your insurance carrier.

I have read and fully understand this statement, and agree to pay for any services not covered by my insurance carrier.

Signature

Date