

*CONFIDENTIAL***Patient Registration Information**

Date _____

Name _____ Soc. Sec # _____

Home Address _____ City _____ State _____ Zip _____

Birth date _____ Home Phone _____ Work Phone _____

Are you: Minor Single Married Divorced Widowed Separated

You or your parent's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____ Business Phone _____

Spouse or parent's name _____ Employer _____ Work Phone _____

If you are a student, name of school/college _____

Whom may we thank for referring you? _____

Person to contact in case of
emergency _____

Responsible Party

Name of person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

City, State, Zip _____ Soc. Sec # _____

Drivers License # _____ Birth date _____

Employer _____ Work Phone _____

Name of Dental Insurance Company _____ Group Number _____ Phone # _____

Ins. co. address _____ City _____ State _____ Zip _____

Additional Insurance

Do you have any additional insurance? Yes No If yes please complete the following:

Name of insured _____ Date employed _____

Name of employer _____ Work Phone _____

Address of employer _____ City _____ State _____

Relationship to patient _____

Birth Date _____ Soc. Sec # _____

Insurance Company _____ Group # _____ Employer/cert.# _____

Ins. co. address _____ City _____ State _____ Zip _____

Medical History

Physician's Name _____ Date of last Physical _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what _____

Are you taking any medication at this time? _____ If so, what _____

For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? __Yes __No Are you nursing __Yes __No

Do you use tobacco? _____ If so, please list the type and amount _____

What was the date of your last cleaning? _____

Do you or have you ever had any of the following? (Check box to indicate yes)

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Allergies to medicine or Drugs | <input type="checkbox"/> "A.I.D.S." or other immunosuppressive Disorders |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Artificial heart valves or joints | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stoke | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Nervous Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Special Diet | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcer | |
| <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Venereal Disease | |

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

Authorization, Release and Agreement to Pay For Services Rendered

I authorize the dentists to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and /or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits other wise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full is expected at each appointment. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

_____ Cash _____ Personal Check _____ Credit Card

Late Charges

If I do not pay the entire balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on the amount or any future outstanding account balances.

Signature of Patient or Parent if minor _____ Date _____