Patient Registration

Today's Date: ________________

Last Name: __________________________ First Name: ______________________ M.I.: _____

Do you prefer to be contacted by: phone, email or text message? Occupation: ___________________

Address: ____

____ZIP: ________________

Home Phone: (____)__________________ Work Phone: (____)______________________

Cell Phone: (____)___________________ email: _______________________________________

Birth date: ________________ Age: ______ Soc. Sec. #:________________________

Gender: Male / Female Marital Status: Single / Married / Divorced / Widowed

Person to contact in an emergency: ________________________ Phone: (____)________________

Address: ____ ZIP: ____________

Insurance Company: ____

Employer Name: ____

Insured's Name: ________________________________ Date of Birth: __________________

Soc. Sec. #: _____________________ Relationship to Patient: ________________________

Group #: ________________________ Insured's I.D. #: ______________________________

I authorize my insurance company to send benefit checks to the doctor. Y / N

Policy holder's signature ____

Who can we thank for referring you to our practice? ____________________________________

Please describe your dental concern: ____

____

Cancellation Policy:

If you are unable to keep your appointment, please give our office at least 24 hours notice. This courtesy allows us to be of service to other patients. Patients who cancel appointments within 24 hours or less are subject to a $25.00 charge ($200.00 for surgery appointments). This charge will be due at the next appointment in addition to any regular copay or coinsurance.

I have been offered a copy of this office's Privacy Policy and Office Policy.

Patient signature: ____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you been under the care of a medical doctor in the past 5 years? Y / N

If yes, for what? ____

Physician's Name: ____________________________________ Phone: (_____)_____________________

Address: ____

Have you been a patient in the hospital in the past 5 years? Y / N

If yes, why? ____

Have you taken any medications in the past 2 years? Y / N

If yes, please list (include non-prescription drugs and supplements)

____

____

Have you had an allergic or bad reaction to any medicine or substance? Y / N

If yes, to what? ____

Do you use tobacco? Y / N How much/often? ____

Are you on a special diet? Y / N

Have you ever taken a bisphosphonate medication (such as Fosamax)? Y / N

Women: Are you pregnant/Trying to get pregnant? Y / N Nursing? Y / N Taking oral contraceptives? Y / N

Indicate which of the following you have had, or have at present:

Heart (surgery, disease, attack)	Arthritis	Neurological Disorders
Congestive heart failure	Ulcers	Kidney trouble
Pacemaker	Acid Reflux (GERD)	Glaucoma
High blood pressure	Thyroid problems	Asthma
High cholesterol	Latex sensitivity	Sleep Apnea
Diabetes	Cancer	Sinus trouble
Osteoporosis/Osteopenia	Tumors	Allergies
Congenital heart defect	Chemotherapy	Hepatitis (A, B, C, unsure, other)
Artificial heart valve	Radiation therapy	Liver Disease
Artificial joint	Bleeding Disorder	HIV positive
Stroke	Nervous/Anxious	AIDS
Seizures	Psychiatric Care	Tuberculosis

Any conditions not listed? ____

Patient Signature: ____ Date: ___________________

Reviewed by Doctor: ____