

**ALL NEW PATIENTS MUST HAVE A VALID PHOTO ID
REGISTRATION INFORMATION**

PATIENT'S NAME _____ AGE _____ BIRTHDATE _____ / _____ / _____
 MAILING ADDRESS _____ CITY _____ ZIP _____ HOME PHONE _____ MO _____ DAY _____ YR _____
 NAME OF SPOUSE/OR PARENTS IF UNDER 18 _____ CELL PHONE _____
 PATIENT'S OCCUPATION _____ BUSINESS PHONE _____
 EMPLOYER _____ /DEPT. _____ EMPLOYER'S ADDRESS _____
 REFERRED BY _____
 WHO WILL PAY FOR THIS ACCOUNT? _____
 REASON FOR TODAY'S VISIT? _____

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE COVERAGE? YES _____ NO _____
 INSURED PERSON'S NAME _____ INSURED PERSON'S SOCIAL SECURITY # _____
 EMPLOYER _____ EMPLOYER'S ADDRESS _____
 NAME & ADDRESS OF INSURANCE CO. _____
 ARE YOU COVERED BY MORE THAN ONE INSURANCE COMPANY? YES _____ NO _____

WE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD

MEDICAL HISTORY

CIRCLE ONE

1. ARE YOU IN GOOD HEALTH? _____	YES	NO
2. ARE YOU NOW OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR? _____	YES	NO
PHYSICIAN _____ ADDRESS _____		
TYPE OF MEDICAL PROBLEMS _____		
3. HAVE YOU EVER HAD ANY SERIOUS ILLNESSES OR OPERATIONS? _____	YES	NO
IF SO, PLEASE LIST AND GIVE DATES _____		
HAVE YOU HAD ANY JOINT REPLACEMENTS? _____		
4. ARE YOU NOW TAKING ANY DRUGS OR MEDICINES? _____	YES	NO
PLEASE LIST _____		
5. DO YOU BLEED EXCESSIVELY AFTER AN EXTRACTION OR DO YOU HAVE ANY BLEEDING PROBLEMS OR ARE YOU TAKING A BLOOD THINNER? _____	YES	NO
6. DO YOU HAVE ANY ALLERGIES OR ARE YOU ALLERGIC TO ANY DRUGS OR MEDICINES? (SUCH AS PENICILLIN, ANY ANTIBIOTICS, NOVOCAINE, LOCAL ANESTHETICS, ASPIRIN, CODEINE, ETC.) _____	YES	NO
PLEASE LIST _____		
ARE YOU ALLERGIC TO LATEX GLOVES? _____		
7. PLEASE CIRCLE THOSE THAT APPLY: DO YOU HAVE A HISTORY OF HEART TROUBLE, HEART ATTACK, HIGH BLOOD PRESSURE, STROKE, ARTERIOSCLEROSIS, RHEUMATIC FEVER, HEART MURMUR, STOMACH ULCERS, LIVER DISEASE, HEPATITIS, TUBERCULOSIS (TB), DIABETES, ASTHMA, EMPHYSEMA, CANCER, SEXUALLY TRANSMITTED DISEASE, OR ANY OTHER INFECTIOUS OR COMMUNICABLE DISEASE OR OTHER MEDICAL PROBLEM? _____	YES	NO
PLEASE LIST ANY OTHER _____		
8. HAVE YOU EVER HAD BAD EFFECTS AFTER DENTAL TREATMENT, EXTRACTIONS OR NOVOCAINE (LOCAL ANESTHETIC) INJECTION? _____	YES	NO
9. WOMEN ONLY: ARE YOU PREGNANT? _____	YES	NO
DUE DATE _____		
10. DO YOU HAVE ANY DISEASE, CONDITION, MEDICAL OR DENTAL PROBLEM NOT LISTED ABOVE THAT YOU THINK WE SHOULD KNOW ABOUT? _____	YES	NO
IF SO, PLEASE EXPLAIN _____		
11. APPROXIMATE DATE OF LAST DENTAL TREATMENT _____		
FORMER DENTIST _____ ADDRESS _____		

I UNDERSTAND THAT ALL FACTS CONCERNING MY HEALTH ARE HELD IN STRICTEST CONFIDENCE. I HAVE ANSWERED THE ABOVE TO THE BEST OF MY KNOWLEDGE. IF THERE ARE FUTURE CHANGES IN MY HEALTH, I WILL NOTIFY THIS OFFICE. IN SUBMITTING MYSELF OR MY CHILD FOR TREATMENT, I AUTHORIZE THE DOCTOR TO UTILIZE METHODS, MATERIALS, DRUGS, AND ANESTHETICS WHICH HE DEEMS BEST.

I UNDERSTAND THAT ALL EMERGENCY TREATMENT AND EXTRACTIONS MUST BE PAID AT THE TIME SERVICES ARE RENDERED.

I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ALL PAYMENT FOR DENTAL SERVICES.

SIGNATURE _____

DATE _____

IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE PARENT OR GUARDIAN SIGN.