PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (__) _____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

E - Mail 1 _____ Cell Phone (__) _____

Sex ___ M ___F Age _____ Birthdate _____

___ Married __ Widowed __ Single __ Minor

___Separated __ Divorced __ Partnered for __ years

Employer /School _____ Occupation _____

Employer /School Address _____ Employer/School Phone (_) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____

Business Address _____ Business Phone (__) _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse/Parent's Social Security # _____

Na me of Dental Insurance Company _____ Group N umber _____

In case of emergency, who should be notified? _____ Phone (__) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check boxes that apply):

D Allergies
D Arthritis
D Artificial Heart Valves or Joints, Screws, etc
D Back Problems
D Bleeding Abnormally
D Blood Disease
D Cancer
D Chemical Dependency
D Chronic Diarrhea
D Circulatory Problems
D Congenital Heart Lesions
D Diabetes
D Epilepsy
D Headaches
D Heart Murmur
D Heart Problems
D Hemophilia
D Hepatitis, Jaundice, or Liver Disease
D Hernia Repair
D High Blood Pressure
D HIV/AIDS
D Low Blood Pressure
D Mitral Valve Prolapse
D Nervous Problems
D Pacemaker
D Psychiatric Care
D Radiation Treatment
D Recent Weight Loss
D Respiratory Disease
D Rheumatic Fever
D Sinus Problems
D Special Diet
D Stroke
D Swollen Neck Glands
D Ulcer
D Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? DYes D No

If so, what? _____

Have you ever responded adversely to medical or dental treatment? - DYes D No

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

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) DYes D No

Are you under the care of a physician? DYes D No For what conditions? _____

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

(Women) Do you suspect that you are pregnant? DYes D No Due date _____

Are you nursing? DYes D No Taking birth control pills? DYes D No

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

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CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to the patient or me. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ Date
Signature of Parent, Guardian or Personal Representative

Please print name of Parent, Guardian, or Personal Representative

Relationship to Patient

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? __ Yes ___ No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____ _

Date

Patient Signature

Date

Dentist Signature

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? __ Yes __ No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____ _____ _

Date

Patient Signature

Date

Dentist Signature