PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT) Home Phone (_____)_____

Patient _____
Last Name First Name Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Cell Phone (_____) _____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Married ☐ Divorced ☐ Single ☐ Minor

Employer/School _____ Work Phone (_____) _____

Subscriber's Name _____ Birthdate _____

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 Social Security #_____

Name of Dental Insurance Company _____ Group Number_____

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? (please circle yes or no):

Allergies	Yes	No	Epilepsy	Yes	No	Pacemaker	Yes	No
Arthritis	Yes	No	Headaches	Yes	No	Psychiatric Care	Yes	No
Artificial Heart Valves or Joints, Screws, etc.	Yes	No	Heart Murmur	Yes	No	Radiation Treatment	Yes	No
Back Problems	Yes	No	Heart Problems	Yes	No	Recent Weight Loss	Yes	No
Bleeding Abnormally	Yes	No	Hemophilia	Yes	No	Respiratory Disease	Yes	No
Blood Disease	Yes	No	Hepatitis, Jaundice or Liver Disease	Yes	No	Rheumatic Fever	Yes	No
Cancer	Yes	No	Hernia Repair	Yes	No	Sinus Problems	Yes	No
Chemical Dependency	Yes	No	High Blood Pressure	Yes	No	Special Diet	Yes	No
Chronic Diarrhea	Yes	No	HIV/AIDS	Yes	No	Stroke	Yes	No
Circulatory Problems	Yes	No	Low Blood Pressure	Yes	No	Swollen Neck Glands	Yes	No
Congenital Heart Lesions	Yes	No	Mitral Valve Prolapse	Yes	No	Ulcer	Yes	No
Diabetes	Yes	No	Nervous Problems	Yes	No	Venereal Disease		

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

If so, what? _____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

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

Are you taking or **have you ever taken** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa? ☐ Yes ☐ No

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO: Latex or Rubber products? ☐ Yes ☐ No

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). ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

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

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due date_____

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

X _____ X_____
Review Medical History - Drs. Signature Patient or Guardian Signature - Date

- O V E R -

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 me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

X _____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
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? _____

Are you 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? _____

Are you taking any new medications? _____ If so, what _____

_____ _____
Date — Patient Signature

_____ _____
Date — Dentist Signature