Patient Registration

Dr. Mr. Miss Mrs. Ms.

Name_____Date of Birth_____**Soc Sec #.**_____**Lic#**_____
Name of Spouse_____**Home Phone**_____**Cell Phone**_____
Residence Address_____City_____State____Zip_____
Employed By_____City_____Business Phone_____
Spouse Employed By_____City_____Business Phone_____
Dental Insurance: Yes___ No___ Insurance Carrier_____Group #_____
Insured Date of Birth_____ Insured SS #_____**Referred By**_____
If Minor
Name of Parent_____Person Responsible for Account_____

I authorize release of any information for insurance, medical or dental purposes.		I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.	
Signed (Patient or Parent if Minor)	Date	Signed (Patient or Parent if Minor)	Date

Physician's Name_____ Phone_____Date of Last Physical Exam_____

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Stroke	Yes	No	Seizures or Convulsions/Epilepsy	Yes	No	Frequent Headaches	Yes	No
Defibrillator/Pacemaker	Yes	No	Herbal Supplement	Yes	No	TMJ/Clicking Joints	Yes	No
Any Heart Problems	Yes	No	Thyroid Condition	Yes	No	Diabetes	Yes	No
Any Heart Surgery	Yes	No	Allergies to Dental Anesthetics	Yes	No	***Hepatitis***	Yes	No
Blood Pressure – High/Low	Yes	No	Anemia	Yes	No	Rheumatic Fever	Yes	No
Mitral Valve Prolapse	Yes	No	Asthma/Emphysema	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No	Tobacco Products	Yes	No	AIDS/HIV Positive	Yes	No
Heart Valve/Replacement	Yes	No	***Artificial Joints Replacement***	Yes	No	Liver or Kidney Disease	Yes	No
Radiation Treatments/Chemo	Yes	No	Bleeding Problems	Yes	No	***Currently taking Aspirin***,	Yes	No
Lupus	Yes	No	Currently taking Blood Thinners	Yes	No	***Fosamax, Actonel, Boniva***	Yes	No
						Other _____		

Are you pregnant? Yes____ What month?_____ Nursing Yes____ No____

What medications are you allergic to: penicillin ____ codeine____ aspirin ____ sulfa ____ other_____

List all medications, drugs or pills you are currently taking_____
_____
Do you need to be ***pre-medicated***? With which antibiotic?_____
_____
Any other medical problems we should be aware of:_____
_____
Do you have any cosmetic concerns?_____
_____
Do you want any missing teeth replaced?_____
How long since you have been to a dentist:_____

I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.

Signature of Patient or Responsible Party_____ Date _____

Email Address:_____