# PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT) Home Phone_____

Patient _____
Last Name First Name Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by_____ Occupation_____

Business Address_____ Business 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 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? (check boxes that apply):

- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Mitral Valve Prolapse
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Allergies to Metals - Jewelry
- ☐ Allergies to Latex
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ AIDS/HIV
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, what _____

_____

Have you ever responded adversely to medical or dental treatment?_____

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

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 Are you nursing? ☐ Yes ☐ No

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

_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature _____

(OVER)

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
*Name of Insurance Company(ies)*

and assign directly to Dr._____all 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
*Date* *Signature*

## MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
*Name of minor/child*

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
*Date* *Signature of Insured/Guardian*

## FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
*Date* *Signature of Insured/Guardian*

## MEDICAL HISTORY UPDATE

Has there been any change in your health since your 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 your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

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

_____ _____
*Date* *Patient Signature*

_____ _____
*Date* *Dentist Signature*

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