

Patient Registration & Medical History

Robert J. Bey, D.D.S.

Date_____ Home Phone_____

Patient's Name_____ Email_____

Preferred Name_____ Cell Phone #_____

Address_____ City_____ Zip_____

Sex: ☐M ☐F Age_____ Birth date_____ Marital Status_____

Social Security #_____

Employer_____ Business Phone _____

Business Address_____ Occupation _____

Name of Spouse/Parent_____ Spouse's Employer_____

Spouse Employer Address_____ Spouse Business Phone_____

Who referred you to our office?_____

INSURANCE INFORMATION

Dental Insurance Co. _____

Group Number_____ Insured's Date of Birth_____

Insured's S.S. #_____

FAMILY MEMBERS IN OUR CARE

MEDICAL HISTORY

Physicians Name_____ Phone Number_____

Are you taking any medications at this time?(please list)_____

Have you ever had? (please circle)

High/Low Blood Pressure	Diabetes	Sinus Trouble
Heart Attack	Epilepsy	Asthma or Hay fever
Heart Surgery	Tuberculosis/Lung Disease	Artificial Knee/Hip
Heart Murmur/ Mitral Valve Prolapse	Glaucoma	Kidney Disease
Rheumatic Fever/ Heart Disease	Ulcer	Thyroid Disease
Congenital Heart Problems	Cancer	Liver Disease
Artificial Heart Valve/Pacemaker	Arthritis	Hepatitis
Stroke	Fibromyalgia	Osteoporosis
Congestive Heart Disease	HIV Infection (AIDS)	Drug/Alcohol Dependency
Anemia	Headaches	Acid Reflux

Are you allergic to: ☐Penicillin ☐Latex ☐Codeine ☐Anesthetics ☐Other Medications_____

Do you smoke or use tobacco products in any form?_____

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

Are you subject to prolonged bleeding? Yes ☐ No ☐

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

Women: Are you taking birth control pills?.....Yes No

Are you pregnant?.....Yes No How many weeks?_____

Are you nursing?.....Yes No

Are you happy with your smile?_____ If not, why?_____

Do you ever have jaw joint (TMJ) pain?_____

Signature_____ Please read other side ➡

Financial Policy

We appreciate payment when services are rendered!

Your account is to be paid in full within 30 days of receipt of your statement unless other arrangements have been made with our office.

Charges not paid within 45 days of receipt of your statement are subject to a finance charge of 1.50% per month (18% annual rate).

To our patients with insurance

As a courtesy to you, we will complete and file insurance forms for your dental treatment. *You are responsible for verifying benefits and coverage percentages.* When benefits are assigned to us, we do not require you to pay the balance in full; we ask only that you pay the *estimated* amount the insurance company will not cover. Balances outstanding 30 days after payment by the insurance company will be subject to a finance charge unless prior arrangements have been made. The ultimate responsibility for this account remains yours. In the event of an extended insurance delay or disputed claim, we may require your immediate payment of the balance.

I have read and understand the above financial policy.

Signature

Date

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