

# Patient Registration



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## 1 Patient Information

Patient's Name \_\_\_\_\_ Occupation \_\_\_\_\_

What name do you prefer we call you? \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_  
Street

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

Phone Home \_\_\_\_\_ Work \_\_\_\_\_

Length of current employment \_\_\_\_\_

Cell \_\_\_\_\_ Email \_\_\_\_\_

Is another member of your family or a relative a patient in our office? If so, who? \_\_\_\_\_

Marital status \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Whom may we thank for referring you to our office. \_\_\_\_\_

## 2 Account Information

Person responsible for account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Same as "Patient Information" above

Occupation \_\_\_\_\_

Address \_\_\_\_\_  
Street

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

Employer \_\_\_\_\_

Phone Home \_\_\_\_\_ Work \_\_\_\_\_

Length of current employment \_\_\_\_\_

Cell \_\_\_\_\_ Email \_\_\_\_\_

Closest relative not living with you

Name	Relationship
_____	_____
Address	Telephone
_____	_____

## 3 Dental Insurance

We will be happy to submit your claims to your insurance company. However, your benefit plan is purchased by your employer, and is not a contract with our office. You are financially responsible for all services rendered.

Primary Insurance Co.

Employer \_\_\_\_\_ Group No. \_\_\_\_\_

Insurance Co. name \_\_\_\_\_

Insurance Co. phone \_\_\_\_\_

Insured's name \_\_\_\_\_

SSN/ID# \_\_\_\_\_ Insured's Birthday \_\_\_\_\_

Secondary Insurance Co.

Employer \_\_\_\_\_ Group No. \_\_\_\_\_

Insurance Co. name \_\_\_\_\_

Insurance Co. phone \_\_\_\_\_

Insured's name \_\_\_\_\_

SSN/ID# \_\_\_\_\_ Insured's Birthday \_\_\_\_\_

## 4 Dental

Purpose of today's visit \_\_\_\_\_

Are you happy with your smile? \_\_\_\_\_ Is there anything you would change? \_\_\_\_\_

Do your gums bleed? \_\_\_\_\_ How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Does heat, cold or sweets cause any discomfort? \_\_\_\_\_

Does biting or chewing on any tooth cause discomfort? \_\_\_\_\_

Have you had difficulty associated with any previous dental experience? \_\_\_\_\_

Who was your former dentist? \_\_\_\_\_ City / State \_\_\_\_\_ Last visit was how long ago? \_\_\_\_\_

Please add anything you feel is important \_\_\_\_\_

## 5 Medical

Our decisions concerning the use of medications, anesthetics and treatments are influenced by your medical status. Please complete thoroughly. This portion of your information is held in strict confidence.

Do you have, or have you had, any of the following conditions? (Circle if yes)

Heart disease	Hepatitis	Kidney Disease	Latex Allergy	Asthma
High Blood Pressure	Chemical Dependency	Sexually transmitted disease	Blood Disease	Cancer
Recent heart surgery	Stomach ulcers	Respiratory Illness	Bruise easily	Diabetes
Rheumatic fever	Prosthetic Implant	Prolonged bleeding	Fainting or seizures	H.I.V.

Please explain \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_ Use tobacco? \_\_\_\_\_

Do you take any medications, vitamins, or herbal supplements? Please list, and the purpose of each one: \_\_\_\_\_

Are there medications you cannot take? \_\_\_\_\_ Please list: \_\_\_\_\_

Women: Are you pregnant? \_\_\_\_\_ Do you anticipate becoming pregnant soon? \_\_\_\_\_

## 6 Please be advised of the following policies that apply to this office

### Credit

1. The responsible person agrees to pay the Doctors at the time services are received unless previous arrangements have been made.
2. If financing is required, credit bureau reports may be obtained.
3. If payments are extended beyond 30 days from the date of the first billing, to pay a service charge of 1.5% per month on the unpaid aged balance (annual rate 18%) with a minimum of \$1.00 per month.

### Appointments

Because my appointment time is reserved exclusively for me, I agree to pay fees for missed appointments or appointments that are cancelled with less than 24 hours notice.

### Privacy

I accept this office's practices protecting the privacy of my health information and give permission to use my information in normal healthcare operations including: appointment scheduling, prescriptions, billing, referrals to specialists, and other situations that may arise.

Date \_\_\_\_\_ Responsible Person \_\_\_\_\_