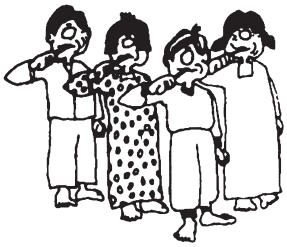
Patient Registration



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1 Patient Information

Patient's Name _____

What name do you prefer we call you? _____

Address _____
Street

_____
City *State* *Zip*

Phone Home _____ Work _____

Cell _____ Email _____

Marital status _____ Birthdate _____ Age _____

Occupation _____

Employer _____

Length of current employment _____

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

_____

Whom may we thank for referring you to our office.

_____

2 Account Information

Person responsible for account _____

❑ Same as "Patient Information" above

Address _____
Street

_____
City *State* *Zip*

Phone Home _____ Work _____

Cell _____ Email _____

Relationship to patient _____

Occupation _____

Employer _____

Length of current employment _____

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 _____

A B C

Please complete other side

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

(You may receive a copy of this form today upon request)