**REGISTRATION** Email:_____

Cell Ph: _____

Patient's Name: _____ Home Ph: _____ Work Ph: _____

Home Address: _____City: _____St: _____Zip:_____

Marital Status: _____ M/F Birth Date: _____ SSN: _____

Occupation: _____ Employer: _____

How long employed: _____ Spouse's Name: _____ Birth Date: _____

Spouse's Occupation: _____ Employer: _____ SSN: _____

Your Driver's License # _____ Referred by: _____

Who is responsible for bill? _____ Physician: _____

Purpose of appointment:_____

## PAYMENT ARRANGEMENTS

( ) I Have No Dental Insurance

( ) I Have Dental Insurance
(_____ Co.)

( ) I Have Secondary Insurance

(_____ Co.)

**All copays and patient portion are due on the day of appointment.**

We accept Cash, Check, Mastercard, Visa and Discover.

Professional care is provided to you, our patient, and not to an insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor**. Dental insurance is not a pay-all**. **Dental plans differ greatly as to deductibles, exclusions, plan maximums, benefits limitations, and co-payments. Actual benefits and patient co-payment responsibilities vary as much as the plans themselves**. We will assist you in submitting your claims and ask that you assign your insurance benefits to us.

Extended payments are available upon special request. All major treatment involving a laboratory procedure will require an appropriate down payment.

**_____** Initial **PLEASE NOTE: We reserve the right to charge for appointments canceled or broken without 24 hours notice.**

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Signature of Patient or Responsible Party if patient is a minor:

X_____ Date: _____

Current Medications: _____

_____

Preferred Pharmacy:_____ Phone #_____

(OVER)

## MEDICAL HISTORY

| | | |
|---|---|---|
| 1. Are you having pain or discomfort at this time? | Y | N |
| 2. Do you feel very nervous about having dentistry treatment? | Y | N |
| 3. Have you ever had a bad experience in the dentistry office? | Y | N |
| 4. Have you been a patient in the hospital during the past two years? | Y | N |
| 5. Have you been under the care of a medical doctor during the past two years? | Y | N |
| 6. Have you taken any medicine or drugs during the past two years? | Y | N |
| 7. **Are you allergic to (i.e., itching, rash, swelling of hands/feet/eyes) or made sick by Penicillin, aspirin, codeine, or any drug?** | Y | N |
| List:_____ | | |
| 8. Have you ever had any excessive bleeding requiring special treatment? | Y | N |

9. Circle any of the following that you have had or have at present:

| | | |
|---|---|---|
| Congestive Heart Failure | Heart Disease | Emphysema |
| AIDS | Cough | Angina Pectoris |
| Hepatitis A | Hepatitis B | Tuberculosis (TB) |
| High Blood Pressure | Asthma | Liver Disease |
| Heart Murmur/Mitral Valve | Hay Fever | Yellow Jaundice |
| PREMED for Dental Appts | Sinus Trouble | Blood Transfusion |
| Congenital Heart Lesions | Drug Addiction | Allergies/Hives |
| Scarlet Fever | Diabetes | Hemophilia |
| Artificial Heart Valve | Thyroid Disease | Venereal Disease |
| Heart Pacemaker | X-ray Treatment | Cold Sores |
| Heart Surgery | Chemotherapy | Genital Herpes |
| **Artificial Joint** | Arthritis | Rheumatism |
| Epilepsy or Seizures | Anemia | Stroke |
| Psychiatric Treatment | Cortisone Medicine | Glaucoma |
| Fainting/Dizzy Spells | Sickle Cell Disease | Kidney Trouble |
| Cancer or Tumor | Bruise Easily | Latex Allergy |

| | | |
|---|---|---|
| 10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are tired? | Y | N |
| 11. Do you use more than two pillows to sleep? | Y | N |
| 12. Have you lost or gained more than ten pounds in the past year? | Y | N |
| 13. Do you ever wake up from sleep short of breath? | Y | N |
| 14. Do you have any disease, condition, or problem not listed? | Y | N |

| | | | |
|---|---|---|---|
| 15. WOMEN | Are you pregnant now?…….. | Y | N |
| | Are you taking birth control pills?…… | Y | N |
| | Do you anticipate becoming pregnant?…….. | Y | N |

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE A CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR AT THE NEXT APPOINTMENT WITHOUT FAIL.

x_____ _____

Signature Patient, Parent or Guardian Date

Permission is hereby granted to the doctor to perform any necessary dental work for this child.

x_____ _____