Patient Registration

Today's Date_____

Last Name _____First Name _____M.I._____

Address_____ Apt. # _____

City _____ State_____ Zip_____

Home Phone _____Work Phone _____Cell Phone_____

Date of Birth _____Age_____ Social Security #: _____

Circle One Marital Status: Single Married Other Sex: Male Female

Employer _____ Email _____

Full Time Student? Y N School Attending _____

Whom can we thank for referring you to us? _____

Person Responsible for Account

Name _____ Employer_____

Address_____ City_____ State_____ Zip_____

Phone Number _____ Social Security Number _____

Relationship to Patient _____ Date of Birth _____

Parent/Guardian Information if patient is a child

Mother's Name_____ Date of Birth _____ SS# _____

Address_____ City _____

State _____ Zip Code _____Work Phone _____

Employer_____ Cell Phone_____

Father's Name_____ Date of Birth _____ SS# _____

Address_____ City _____

State _____ Zip Code _____Work Phone _____

Employer_____ Cell Phone_____

Emergency Contact Information

Name_____ Phone Number_____

Relationship to Patient _____

Patient Primary Dental Insurance

Insured Name _____ Date of Birth_____ SS#_____

Insured Address _____

Insurance Name _____ Phone Number_____

Employer_____ Insurance Group Number_____

Patient Secondary Dental Insurance

Insured Name _____ Date of Birth_____ SS#_____

Insured Address _____

Insurance Name _____ Phone Number_____

Employer_____ Insurance Group Number_____

Please list family member or significant others, if any, whom we may inform about

Your dental treatment, payment and account information: _____

_____

Date of your last dental cleaning _____

Have you been treated for gum disease or have you been told you have gum disease in the past? Yes No Unsure Please explain _____

Are you having any dental problems? _____

I understand that I am responsible for all charges for a service provided. If insurance applies, I understand that I am responsible for any remaining unpaid balances. I also understand it is my full financial ability to pay all court costs, fees and any attorney fees if my account is turned over for collections. As a service to our patients we file insurance for services rendered. However, we do consider the patient responsible for the account. When payment of insurance claim is assigned to us that estimated portion of the fee which is payable by the patient is due at the time of service.

Signature **Date**

Patient Medical History

Date _____

Primary Care Physician _____Phone Number _____

Pharmacy Preference (include location) _____

Please circle any of the following that apply to you

Acid Reflux	Epilepsy	Radiation Treatment
Arthritis	Headaches/Migraine	Respiratory Disease
Artificial Joints	Heart Attack	Seizures
Asthma	Heart Stents	Sinus
Back Problems	Heart Valves	Stroke
Bypass Surgery	Hepatitis A, B, or C	Smoker
Blood Disease	High Blood Pressure	Smokeless Tobacco
Blood Thinner	HIV/AIDS	Thyroid
Cancer	Immunosuppressive Disorders	Tuberculosis
Diabetes	Jaundice/Liver Disease	Ulcer

Drug/Alcohol Dependent

Other _____

List any surgeries you have had including dates _____

_____

Do you have allergies to any of the following? (Please circle all that apply)

Aspirin	Ceclor	Codeine	Dental Anesthetic	Erythromycin	Keflex
Latex	Penicillin	Sulfa			

Other _____

Are you taking or have you ever taken bisphosphonates in the past to treat osteoporosis? (Example: Fosamax or Prolia) Yes No If so when_____

Women – Are you pregnant? _____

Are you taking medications? _____ if so, please list on the following page

Patient Medications

List of Medication

Medication Name	Dosage and Milligram	Reason
Example: Aspirin	**1 time day 81mg**	**Stroke**

Acknowledgment of Privacy Notice

I, _____, have been informed about the copy of this Office Notice of the Privacy Practice. Stating that my dental information will not be given out to anyone without my permission.

Signature _____ Date _____

Please list the names of persons that we may share your records with.

Name_____ Relationship_____Phone Number_____

Name_____ Relationship_____Phone Number_____

Name_____ Relationship_____Phone Number_____

May we share your dental records with other dentists or dental specialists? Yes/No