PATIENT REGISTRATION

PATIENT INFORMATION

First Name_____

Last Name_____ MI____

Birthday_____ Salutation_____

Address_____

City_____ State_____ Zip_____

Home Ph_____ Best Contact # _____

Gender: ☐ Male ☐ Female SS# _____

Policy Holder's Employer _____

POLICY HOLDER

First Name_____

Last Name_____ MI____

Address_____

City_____ State_____ Zip_____

Home Ph_____ Best Contact # _____

Birthday_____ SS# _____

Gender: ☐ Male ☐ Female

Insurance Company _____

HEALTH INFORMATION:

UPDATES

Date _____

Dr. Signature _____

Date _____

Dr. Signature _____

Date _____

Dr. Signature _____

	YES	NO
1. RHEUMATIC FEVER	☐	☐
2. HEART MURMUR	☐	☐
3. HEART TROUBLE	☐	☐
4. PACEMAKER/OPEN HEART SURGERY	☐	☐
5. HIGH BLOOD PRESSURE	☐	☐
6. LOW BLOOD PRESSURE	☐	☐
7. BLOOD DISEASE	☐	☐
8. HIV POSITIVE	☐	☐
9. DIABETES	☐	☐
10. EXCESSIVE BLEEDING	☐	☐
11. DO YOU BRUISE EASILY	☐	☐
12. ANEMIA	☐	☐
13. KIDNEY DISEASE	☐	☐
14. ULCERS OR STOMACH PROBLEMS	☐	☐
15. LIVER DISEASE	☐	☐
16. HEPATITIS	☐	☐
17. LUNG DISEASE	☐	☐

	YES	NO
18. BREATHING PROBLEMS	☐	☐
19. TUBERCULOSIS	☐	☐
20. ASTHMA	☐	☐
21. EPILEPSY	☐	☐
22. ALLERGIES TO DRUGS (SPECIFY BELOW)	☐	☐
23. ADVERSE REACTIONS TO ANY DRUGS	☐	☐
24. FAINTING OR DIZZINESS	☐	☐
25. DO YOU TAKE MEDICATIONS	☐	☐
26. ARE YOU PREGNANT? MONTHS_____	☐	☐
27. VENEREAL DISEASE HERPES	☐	☐
28. ARTHRITIS	☐	☐
29. OTHER ILLNESS	☐	☐
30. PRESENTLY UNDER CARE OF PHYSICIAN	☐	☐
31. HAD TROUBLE FROM PREVIOUS DENTAL CARE	☐	☐
32. PAIN IN YOUR JAW OR NEAR YOUR EARS	☐	☐
33. UNHEALED INJURIES OR INFLAMED AREAS IN OR AROUND YOUR MOUTH	☐	☐

	YES	NO
34. GROWTHS OR SPOTS IN YOUR MOUTH	☐	☐
35. MOUTH HURT WHEN CLENCHED	☐	☐
36. EVER HAD NOVOCAINE OR OTHER LOCAL ANESTHETIC	☐	☐
37. EVER HAD NITROUS OXIDE (LAUGHING GAS)	☐	☐
38. EVER HAD GENERAL ANESTHESIA	☐	☐
39. ANY REACTION/ALLERGIC SYMPTOMS TO NOVOCAINE, LOCAL OR GENERAL ANESTHETICS	☐	☐
40. ANY DIFFICULT EXTRACTION IN THE PAST	☐	☐
41. PROLONGED BLEEDING FOLLOWING EXTRACTION IN THE PAST	☐	☐
42. DO YOUR GUMS BLEED	☐	☐
43. BAD TASTE IN YOUR MOUTH OR MOUTH ODOR	☐	☐
44. EVER GIVEN INSTRUCTIONS ON CARE OF GUMS	☐	☐
45. CHEW ONLY ON ONE SIDE OF MOUTH	☐	☐
46. HABITUALLY CLENCH OR GRIND YOUR TEETH DURING THE DAY OR NIGHT	☐	☐
47. ANY PART OF MOUTH SENSITIVE TO PRESSURES OR IRRITANTS (HOT, COLD, SWEET)	☐	☐
48. TOBACCO USER	☐	☐

COUMADIN PATIENT **PREMEDICATE**

ARE YOU ALLERGIC TO ANY MEDICATIONS?

1._____ 2._____

3._____ 4._____

LIST ANY MEDICATIONS YOU ARE TAKING:

1._____ 2._____

3._____ 4._____

MEDICAL INFORMATION:

Date of Last Physical_____ Physician_____ Phone _____

Emergency Contact_____ Phone_____ Pharmacy_____ Phone _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:	**Date:**

CONSENT FOR SERVICES:

I understand that I am financially responsible (regardless of my insurance status) for all charges for services rendered to me, including the balance remaining after payment of possible insurance benefits. I further agree that a waiver of any breech of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted here under. I authorize payment of medical expenses to the provider of professional services rendered. I authorize release of any medical information necessary to process claims. I certify the above information to be true and correct to the best of my knowledge.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Signature of Patient, Parent or Guardian:	**Date:**	**Relationship to patient:**
Signature of Guarantor of payment/responsible party:	**Date:**	**Relationship to patient:**