

REGISTRATION



PATIENT'S NAME _____
PATIENT'S SOCIAL SECURITY NUMBER _____
IF A CHILD, PARENT'S NAME _____
STREET ADDRESS _____ PHONE _____
CITY _____ STATE _____ ZIP _____
EMAIL _____ CELL PHONE _____
PATIENT EMPLOYED BY _____ PHONE _____
PRESENT POSITION _____
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____
PHONE _____
PURPOSE OF THIS APPOINTMENT _____
WHOM MAY WE THANK FOR REFERRING YOU? _____

MEDICAL HISTORY

DATE OF BIRTH _____
NAME OF PHYSICIAN _____ PHONE _____

Are you under a physician's care now? Yes No
If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No
If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No
If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No
If yes, please list: _____

Do you take, or have you taken Phen-Fen or Redux? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you

Pregnant/Trying to get pregnant?

Taking oral contraceptives?

Nursing?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other, if yes, please explain: _____

Do you have, or have had, any of the following?

- | | | | | |
|-------------------------------------------------|----------------------------------------------------|------------------------------------------------|------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> AIDS/ HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

HOW WILL ACCOUNT BE PAID? (Check all that apply)

CASH CHECK MC/VISA/DISCOVER DENTAL INSURANCE

DENTAL INSURANCE INFORMATION

COVERED EMPLOYEE NAME _____ DATE OF BIRTH _____
SOCIAL SECURITY NUMBER OF COVERED PERSON _____
EMPLOYER _____
NAME OF INSURANCE COMPANY _____
INSURANCE COMPANY PHONE NUMBER _____
GROUP NUMBER _____

OFFICE POLICY REGARDING DENTAL INSURANCE

Insurance policies vary as to their provisions and exclusions. We suggest that you review your dental policy so that you may be aware of the specific limitations of your dental contract. As a courtesy to you, we will process your dental insurance claim forms. You will be responsible for all fees not covered by your insurance plan. Our office staff will do their best to provide you with an accurate estimate of these expenses which include deductibles and copayments. Please be advised that due to the ever changing nature of the insurance marketplace, these figures represent an estimate. We request that you pay deductibles and copayments at the time of service.

For patients enrolled in dental PPO's, in order for us to offer premium service at substantial discounts, we require payment for routine care at the time of service. Exceptions may be made in cases of dental emergencies such as trauma or major infections, or for pre-approved payment plans for comprehensive dental/orthodontic treatment.

NOTICE OF FINANCIAL RESPONSIBILITY

There is a \$40 service fee for all returned checks.

Patients will be sent a bill for all unpaid balances. Any additional bill will carry a \$2 service fee. If an account is left unpaid for more than 60 days, the patient will be sent a Final Notice. If the account is not cleared within the next 30 days, it will be turned over to our collection agency and a 15% collection fee will be added to the charges accrued.

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.
I authorize release of information to all my insurance Companies.
I understand that I am responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance Company.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.
My signature also applies to the dependents listed at right.

Dependents

Patient's Signature

Date