WELCOME

PATIENT REGISTRATION / HEALTH HISTORY

DATE___/___/___ PATIENT'S SOCIAL SECURITY # _____-____-_____

NAME:_____ HOME ADDRESS_____

CITY_____ STATE_____ ZIP_____

M__F__ __MARRIED __SINGLE __CHILD __OTHER_____

DATE OF BIRTH___/___/_____ HOME PHONE_____WORK_____EXT_____

CELL PHONE_____ E-MAIL:_____

EMPLOYER:_____

THE REASON FOR TODAY'S VISIT _____

*WILL OUR OFFICE BE FILING INSURANCE FOR YOU ? ___ Y ___ N

PATIENT'S HEALTH INFORMATION

ARE YOU ALLERGIC TO ANY MEDICATION ? _____

[PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY]

__AIDS
__ALLERGIES
_____
__ANEMIA
__ARTHRITIS
__ARTIFICIAL JOINTS
__ASTHMA
__BLOOD DISEASE
__CANCER
__DIABETES
__DIZZINESS
__EPILEPSY
__EXCESSIVE BLEEDING
__FAINTING
__GLAUCOMA
__GROWTHS
__HAY FEVER
__HEAD INJURY
__HEART DISEASE
__HEART MURMUR
__HEPATITIS (A,B OR C)
__HIGH BLOOD PRESSURE
__JAUNDICE
__KIDNEY DISEASE
__LIVER DISEASE
__MENTAL DISORDERS
__NERVOUS DISORDERS
__PACEMAKER
__ARE YOU PREGNANT
DUE DATE:_____
__RADIATION TREATMENT
__RESPIRATORY PROBLEMS
__RHEUMATIC FEVER
__RHEUMATISM
__SINUS PROBLEMS
__STOMACH PROBLEMS
__STROKE
__TUBERCULOSIS
__TUMORS
__ULCERS
__VENEREAL DISEASE
__ADD
OTHER_____
_____
_____
_____
_____
_____

*HAVE YOU EVER HAD ANY COMPLICATIONS FOLLOWING DENTAL TREATMENT? ___YES ___NO
IF YES, PLEASE EXPLAIN:_____

*HAVE YOU BEEN ADMITTED TO A HOSPITAL OR NEEDED EMERGENCY CARE DURING THE PAST TWO YEARS?
__YES __NO IF YES, PLEASE EXPLAIN:_____

*ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? __YES __NO
IF YES, PLEASE EXPLAIN:_____

*NAME OF PHYSICIAN:_____ PHONE # _____

*PLEASE LIST ANY MEDICATION THAT YOU ARE CURRENTLY TAKING:_____

REFERRED BY:_____

Notes:_____

SPOUSE OR RESPONSIBLE PARTY

NAME:_____HOME ADDRESS_____

CITY:_____STATE:_____ZIP_____

SOCIAL SECURITY #:_____DATE OF BIRTH:_____

PHONE: (HOME)_____(WORK)_____

EMPLOYER:_____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE:

NAME OF INSURED:_____IS INSURED A PATIENT? ___Y___N

INSURED'S DATE OF BIRTH:_____ID#:_____GROUP#:_____

INSURED'S ADDRESS:_____

INSURED'S EMPLOYER:_____WORK#:_____

YOUR RELATIONSHIP TO THE INSURED:___SELF___SPOUSE___CHILD___OTHER

THE NAME OF THE INSURANCE CO.:_____

ADDRESS:_____

SECONDARY DENTAL INSURANCE:

NAME OF INSURED:_____IS INSURED A PATIENT?___Y___N

INSURED'S DATE OF BIRTH:_____ID#:_____GROUP#:_____

INSURED'S ADDRESS:_____

INSURED'S EMPLOYER:_____WORK#:_____

YOUR RELATIONSHIP TO THE INSURED:___SELF___SPOUSE___CHILD___OTHER

THE NAME OF THE INSURANCE CO:_____

CONSENT FOR SERVICES

THIS PRACTICE DEPENDS UPON REIMBURSEMENT FROM THE PATIENTS FOR THE COSTS INCURRED IN THEIR CARE.

ALL EMERGENCY DENTAL SERVICES PERFORMED MUST BE PAID FOR IN CASH AT THE TIME SERVICES ARE PERFORMED.

PATIENTS WHO CARRY DENTAL INSURANCE UNDERSTAND THAT ALL DENTAL SERVICES ARE CHARGED TO THE PATIENT. ANY PRE - AUTHORIZATIONS OR QUOTES GIVEN BY THE INSURANCE COMPANY ARE ESTIMATES AND NOT A GUARANTEE OF PAYMENT.
OUR OFFICE WILL HELP PREPARE THE PATIENT'S INSURANCE FORMS OR ASSIST IN MAKING COLLECTIONS FROM INSURANCE COMPANIES AND WILL CREDIT ANY SUCH COLLECTIONS TO THE PATIENT'S ACCOUNT. *HOWEVER, THIS OFFICE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT OUR CHARGES WILL BE PAID BY AN INSURANCE COMPANY.*

A SERVICE CHARGE OF 1 ½% PER MONTH (18% PER ANUM) ON THE UNPAID BALANCE WILL BE CHARGED ON ALL ACCOUNTS EXCEEDING 60 DAYS.
I UNDERSTAND THAT TREATMENT PLAN FEE ESTIMATES CAN ONLY BE EXTENDED FOR A PERIOD OF 6 MONTHS FROM THE DATE OF THE PATIENT EXAMINATION.

IN CONSIDERATION FOR THE PROFESSIONAL SERVICES RENDERED TO ME, OR AT MY REQUEST, BY THE DOCTOR, I AGREE TO PAY THE REASONABLE VALUE OF SAID SERVICES TO THE DOCTOR AT THE TIME SERVICES ARE RENDERED, OR WITHIN 5 DAYS OF BILLING. I FURTHER AGREE THAT THE REASONABLE VALUE OF SAID SERVICES SHALL BE AS BILLED UNLESS OBJECTED TO, BY ME, IN WRITING, WITHIN THE TIME FOR PAYMENT THEREOF. I FURTHER AGREE THAT A WAIVER OF ANY BREACH OF ANY TIME OR CONDITION HEREUNDER 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 HEREUNDER.

I GRANT MY PERMISSION TO YOU OR YOUR ASSIGNEE, TO TELEPHONE ME AT HOME OR WORK TO DISCUSS MATTERS RELATED TO THIS FORM.
I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENT.

SIGNED_____DATE_____RELATION TO PATIENT_____