REGISTRATION FORM

Today's Date:_____

Patient's Name:_____
LAST FIRST M.I.

Birthdate:_____ Age:_____

Single_____ Married_____ Separated_____ Widowed_____ Divorced_____

Name of Spouse:_____ If Child - Parent's Name_____

	LOCAL Address	BUSINESS Address	OUT of STATE Address
Street:	_____	_____	_____
City:	_____	_____	_____
State/Zip:	_____	_____	_____

Tel: _____ Cell: _____ E-mail_____

Patient Employed By:_____ Position_____ # years:_____

Patient's Social Security Number:_____

Referred by:_____

Purpose of Appointment:_____

Who will pay this account:_____

Are you covered by dental insurance: ❑ YES ❑ NO

DENTAL INSURANCE INFO: (primary carrier)

Insured's Name_____

Insurance Co._____

Insurance Co. Address_____

_____

Insured's Employer_____

Insured's Soc. Sec. #_____

Group # _____

If you have double insurance coverage - complete this for the second coverage:

Insured's Name_____

Insurance Co._____

Insurance Co. Address_____

_____

Insured's Employer_____

Insured's Soc. Sec. # _____

Group # _____

PLEASE TURN THE PAGE OVER TO FILL OUT IMPORTANT MEDICAL & DENTAL QUESTIONNAIRE!!!

The undersigned hereby authorizes the Doctor to take x-rays, photographs, study models, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's Dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand any portion of treatment not covered by my Insurance is due and payable by me. My Insurance is a contract between me and my Insurance carrier, not between the Insurance carrier and the Doctor. I assign all Insurance benefits to the Doctor. I understand that when necessary, credit bureau reports may be obtained.

Patient signature (parent if child)_____ Date_____

Are you presently taking or have taken oral or intravenous bisphosphonates:
Fosamax, Actonel, Boniva, Disronel, Skelid, Zometa, Aredia, or Bonefos? ..... ❑ Yes ❑ No

Are you allergic to:

Latex ..... ❑ Yes ❑ No
Penicillin ..... ❑ Yes ❑ No
Other medications ..... ❑ Yes ❑ No

Please List Medications _____

_____

Have you ever had any abnormal reaction to local anesthetic:..... ❑ Yes ❑ No

Do you suffer from any of the following:

Abnormal Heart Condition ..... ❑ Yes ❑ No
Heart Valve Replacement ..... ❑ Yes ❑ No
Pacemaker ..... ❑ Yes ❑ No
Rheumatic Fever ..... ❑ Yes ❑ No
Heart Murmur ..... ❑ Yes ❑ No
Mitral Valve Prolapse..... ❑ Yes ❑ No
Implant (artificial joint replacement, knee, hip implant) ..... ❑ Yes ❑ No
HIV Positive ..... ❑ Yes ❑ No
Hepatitis ..... ❑ Yes ❑ No

Have you ever received any radiation therapy in head or neck region? ..... ❑ Yes ❑ No

Other physical conditions we should be aware of: _____

_____

Please list any medications you are currently taking: _____

_____

Name of Physician:_____**Phone #**_____

Is there any other Medical or Dental Information we should know? _____

_____

To the best of my knowledge, the above medical and dental history is complete and accurate.
PATIENT is responsible for advising this office of any change in Medical History.

Patient Signature: _____