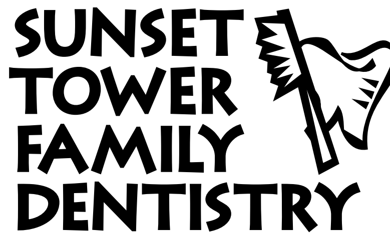
Welcome!



Please complete or update the following Patient Information and Medical History (on back). Thank You!

Patient Registration

Please Print

Patient Name: ______________________ Date of Birth: __________

How do you wish to be addressed? ______________________ Present Age: __________

Street Address: ______________________

City: __________ State: ______ Zip: ______

Phone #s: Home: ( ) __________ Work: ( ) __________ Cell: ( ) __________

Email Address: ______________________ Social Security Number: __________

Patient Employed By: ______________________ How Long: __________

Spouse Employed By: ______________________ How Long: __________

Contact in case of emergency: ______________________ Phone #: ( ) __________

Who is responsible for payment for this account (if other than patient)? __________

If the patient is a minor, please give us the name of the parents or guardian:

Father: __________ Mother: __________ Guardian: __________

Who can we thank for referring you to our practice? ______________________

Our services are offered on the basis that all charges will be paid by the patient at the time of service. If you would like to make special payment arrangements, please discuss your needs with one of our financial coordinators prior to beginning treatment and we'll be happy to assist you.

Insurance Information

Patients are responsible for all costs of treatment regardless of insurance coverage. We will be happy to submit and accept your insurance for you if you provide us with complete information. Please have your current dental insurance card with you on your first visit, and be sure to update us if there are any future changes in your coverage. All workman's compensation claims must be approved by your employer before treatment begins.

Primary Insurance Carrier

Employee Name __________

Employee SSN __________

Employee Date of Birth __________

Insurance Co. Name __________

Insurance Co. Phone __________

Address for Claims __________

Program/Policy Number __________

Union or Local __________

Secondary Insurance Carrier

Employee Name __________

Employee SSN __________

Employee Date of Birth __________

Insurance Co. Name __________

Insurance Co. Phone __________

Address for Claims __________

Program/Policy Number __________

Union or Local __________

Medical History

Patient Name ______________________________

Name/Phone number of Family Physician (in case of emergency): ______________________

Do you have any CURRENT HEALTH PROBLEMS? ______________________

Do you take an antibiotic prior to dental treatment? If so, why? ______________________

List all medications you are CURRENTLY taking: ______________________

____

____

Are you ALLERGIC to any of the following medications? (Please CIRCLE all that apply)

Asprin	Local Anesthetic	Sulfa
Codeine	Nitrous Oxide	Tetracycline
Erythromycin	Penicillin	Valium
Latex	Percodan	Other: ______________

Have you ever taken Bisphosphonates for Osteoperosis? ______________________

Do you smoke? If yes, how much and for how long? ______________________

Do you use chewing tobacco? If yes, how much and for how long? ______________________

Please CIRCLE any of the following problems/conditions that apply to you:

AIDS	Depression	Liver Disease
Allergies	Drug Addiction	Low Blood Pressure
Anemia	Emphysema	Mitral Valve Prolapse
Angina (Chest Pain)	Epilepsy	Venereal Disease
Arthritis	Excessive Bleeding	Pace Maker
Artificial Heart Valve	Fainting	Pregnant
Artificial Joint(s)	Glaucoma	Radiation (Head/Neck)
Asthma	Heart Conditions	Respiratory Issues
Blood Disease	Hepatitis A	Seizures
Bruise Easily	Hepatitis B	Sinus Problems
Cancer	Hepatitis C	Stomach Problems
Chemotherapy	High Blood Pressure	Stroke
Diabetes	HIV Positive	Thyroid Disease
Dizziness	Jaundice	Tuberculosis
	Kidney Disease	Other: ______________

**The above medical history is true to the best of my knowledge and I consent to routine procedures deemed necessary for diagnosis and treatment.

Patient Signature: ______________________ Date: ______________

**My initials below indicate that I have reviewed the above medical history and believe it to be true on the date specified.

MEDICAL HISTORY UPDATE									
	Initials								
	Date								