

Patient Registration & Insurance

Patient Information

Today's Date _____

Patient Name _____

Last

First

Middle Initial

Prefers to be called _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-MAIL ADDRESS _____

***Where do you prefer to be called in the evening? _____

Social Security Number _____ Date of Birth _____ Gender Male Female

Employer _____ Work Phone _____ Ext _____

May we call you at work? Yes No

Marital status: Single Married Divorced Widowed

Spouse or Parent Information

Name (or parent if the patient is a minor) _____

Last

First

Middle Initial

Address ("same" is acceptable) _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Other Phone _____

Employer _____ Work Phone _____ Ext _____

Social Security Number _____ Date of Birth _____ Gender Male Female

Whom should we contact in case of emergency? _____ Phone _____

Person financially responsible for account _____

Last

First

Middle Initial

Referral Information

Whom may we thank for referring you to our practice? _____

Complete this section if you have dental insurance (s)

Primary Insurance

Insured's Name (As appears on card) _____

Insurance Carrier _____ Group # _____

Employer _____

Insured's Birthdate _____

Social Security # _____

Relationship Self Spouse Child

Secondary Insurance

Insured's Name (As appears on Card) _____

Insurance Carrier _____ Group # _____

Employer _____

Insured's Birthdate _____

Social Security _____

Relationship Self Spouse Child

OVER →

Patient Name _____ Date _____

Health Questionnaire & Medical Information

Do you have or have you ever had:

Heart Disease

- | | | |
|--|---|---|
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Chemotherapy / Radiation Therapy | <input type="checkbox"/> Nervous / Anxious |
| <input type="checkbox"/> Artificial Heart Valve / Stent | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Cold Sores / Fever Blisters | <input type="checkbox"/> Psychiatric / Psychological Care |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diet (restricted / special) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Surgery: (last 5 years) |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Glaucoma | ----- |
| <input type="checkbox"/> Pacemaker Surgery | <input type="checkbox"/> Hay Fever | ----- |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing Difficulties | ----- |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis A, B or C / Jaundice | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disorders / Bleeding Problems | <input type="checkbox"/> A.I.D.S | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Kidney Problems / Dialysis | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Cancer: <i>please list type with year</i> | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Venereal Disease / STD's |
| ----- | ----- | <input type="checkbox"/> Other _____ |

Women - Are you: Pregnant? Yes, ___ months No **Nursing?** Yes No **Taking birth control pills?** Yes No

- * Have you ever had to premedicate before having dental treatment? Yes No
- * Are there any impending operations, or other information that we should be aware of? Yes No
- * Are you **Allergic** or have you had an adverse reaction to any medication or substance? Yes No

Please list: _____

List Medications Currently Taking	Reason

Physicians Name _____ Last Physical Examination _____
 Date of last dental visit _____ Reason for visit _____

Consent for Treatment

Read Carefully and Understand What Your Signature Means

Your signature below serves many purposes. It indicates you have reviewed your medical history above and updated and corrected it as appropriate. It also indicates you have reviewed your personal registration information on the other side of this paper (especially your phone numbers) to ensure that it is correct. Also, your signature below shall constitute your "Signature on File" with your insurance company (if applicable) for assignment of your insurance benefits to ~~W&R~~ **Dentistry** and the release of information to all insurance carriers.

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough
2. diagnosis of (name of patient) _____'s dental needs.
3. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
4. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
5. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identified as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

XSignature _____	Date _____	Dr. _____	Date _____
Signature _____	Date _____	Dr. _____	Date _____
Signature _____	Date _____	Dr. _____	Date _____
Signature _____	Date _____	Dr. _____	Date _____
Signature _____	Date _____	Dr. _____	Date _____

Over ----->