

PATIENT REGISTRATION

Patient Name: _____ Preferred Name: _____ Birthdate: _____

SS #: _____ Emergency Contact: _____ Number: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____

E-Mail Address: _____ I would like to receive correspondence via e-mail.

Male: _____ Female: _____ Marital Status: Married Single Divorced Separated Widowed

Patient's Employer: _____ Address: _____

Spouse (or parent) Name: _____ SS # _____ Phone # _____

Spouse (or parent) Employer: _____ Phone # _____

Person Responsible for Account _____ SS # _____ Birthdate: _____

Address (if different from above) _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____

Do you have dental insurance? _____ Name of Primary Insurance: _____ Secondary: _____

Responsible Party is also Insurance Policy Holder for Patient? _____ Relation to Patient: _____

Whom may we thank for referring you to this Office? _____

Your General Health: _____ Excellent _____ Good _____ Fair _____ Poor. Are you currently being treated by a medical doctor: _____

If so, for what? _____

Are you currently taking medications? _____ If so, for what? _____

Name of your Medical Doctor: _____ Phone: _____

Date of last Physical Examination: _____ Date of last Dental Examination: _____

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

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Blood Disease/Clotting | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Head/Neck Injury | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Venereal Disease |

Tobacco Use? _____ How often? _____ Alcohol Use? _____ How often? _____

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Latex Local Anesthetics

Do you have any other condition not mentioned above that you think we should know about? _____

Payment is due when services are rendered. A finance charge will be billed on unpaid balances greater than 30 days old. All cost incurred in the collection of any outstanding balance, including but not limited to reasonable attorney fees are the responsibility of the patient and/or responsible person listed on this form.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.
A \$35 SERVICE CHARGE FOR CANCELLATIONS WITH LESS THAN 24 HOUR NOTICE.

X _____ Date: _____

Signature of Patient (or parent/guardian if minor)