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?

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