MEDICAL HISTORY

Who is your Family Physician? ______________________ Phone: ______________________

Have you seen a physician for a medical condition in the last 6 months? ☐ No ☐ Yes **Date:** ____________

Have you had an operation, illness, or been hospitalized in the last 5 years? ☐ No ☐ Yes **Reason?** ____________

Accurate and complete disclosure of medical information is necessary for proper diagnosis and to help prevent unnecessary complications during your treatment.

Please check the box for any condition you have now or had in the past.

(Parent/Guardian: please check the appropriate boxes concerning your child's health status.)

☐ Anemia
☐ Asthma/Hay Fever
☐ Arthritis
☐ Blood Disease
☐ Blood Transfusion
☐ Cancer or Tumor
☐ Chest Pain
☐ Diabetes
☐ Epilepsy/Seizures
☐ Fainting
☐ Frequent Headaches
☐ Glaucoma
☐ Heart Attack
☐ Heart Murmur
☐ Heart Surgery
☐ Hepatitis/Jaundice
☐ High/Low Blood Pressure
☐ HIV/AIDS (or another STI)
☐ Kidney/Bladder Trouble
☐ Liver Disease
☐ Mental Disorders
☐ Prolonged Bleeding
☐ Prosthetic Joint Replacement
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Shortness of Breath
☐ Sinus Trouble
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis

Please list any Medical Conditions or concerns that are not mentioned about and the Doctor should be aware of:

____

____

PREFERRED PHARMACY

Name: ______________________ **Location:** ______________________

Phone # ______________________ **Fax #** ______________________

Please Check any medications you are currently taking or have taken:

☐ ***NONE***

☐ Anticoagulants
☐ Blood Thinners
☐ Cortisone Drugs
☐ Sedatives
☐ Steroids
☐ Tranquilizers

Are you taking any other medication(s)? ☐ No ☐ Yes, Please Explain ______________________

Are you allergic to or suffer ill effects from any of the following?

☐ ***NO KNOWN ALLERGIES***

☐ Aspirin
☐ Codeine
☐ Dental Anesthesia
☐ Household Bleach
☐ Penicillin
☐ Other ______________

Women Only: Are you Pregnant? ☐ No ☐ Yes, How many months? ____________

Are you presently taking any kind of medicine routinely? (Birth control pills, shots, implant, hormone therapy, etc.)

Please Explain: ____

____

ALL: To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change I will inform the Dentist at my next appointment

I have received the Notice of Privacy Practice and understand my healthcare information may be disclosed as outlined within that notice.

Signature: ______________________ **Date**: ____________

Thank You.

CONFIDENTIAL PATIENT REGISTRATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Patient Name:____
Last Name First Name Middle Initial

Preferred Name:________________________________

Check one: ☐ Married ☐ Single ☐ Widowed

Address:____
Street City State Zip code

Date of Birth:____/____/________ CHECK : ☐ Male ☐ Female **SSN:** ____________________
MM DD YYYY

Preferred method of contact :

Phone: ______________________ ☐ **Home** ☐**Work** ☐**Cell** Email:____

Emergency Contact Name: ________________________ **Phone :** ____

How did you hear about us? Or Whom May We Thank For Referring You?

____

RESPONSIBILE PARTY/BILLING INFORMATION

Person Responsible for Account (if different from above):______________________ Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other

SSN: ____–______–______ **Date of Birth:** ______/____/________
MM DD YYYY

Preferred method of Contact: Phone ______________________ **EMAIL:**________________________________

Address if different from patients: ____
Street City State Zip code

DENTAL INSURANCE INFORMATION

Do you have secondary dental insurance? ☐ **Yes** ☐ **No**

Please enter **PRIMARY** insurance information below: **Relationship to Policy holder :** ☐ Spouse ☐ Parent ☐ Other

Name of Primary Policyholder: _________________________ **Policyholder DOB:** __________________ ☐ Male ☐ Female

Employer: __________________________ **Insurance Company:** ____________________________

Insurance Company Phone #: ____________________**Subscriber ID#**____________________________

I am aware that a copy of my insurance identification card will be made available and a copy kept in my records. I am responsible for updating this information if and when there are changes.

Payment Method – Informed Consent

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential.

Thank You.

We gladly welcome any questions regarding fees and discussing your financial options prior to treatment.

Note: **All balances are due at time of service. We accept Cash, Check, Visa, and MasterCard**

I authorize my insurance carrier to issue dental/medical benefits directly to this office and the release of any information necessary to process the insurance claim

Signature: ____ **Date:** ______________