

REGISTRATION AND TREATMENT

Date _____

Home Phone (_____) _____

Cell Phone (_____) _____

PATIENT INFORMATION

Name _____	Last Name _____	First Name _____	Middle Initial _____	Social Security # _____
Address _____		E-mail _____		
City _____		State _____		Zip _____
Sex <input type="checkbox"/> M	<input type="checkbox"/> F	Age _____	Birthdate _____	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor
				<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years
Patient Employer/School _____		Occupation _____		
Employer/School Address _____		Employer/School Phone (_____) _____		
Whom may we thank for referring you? Circle > Google ZocDoc Website Insurance Referred by Doctor/Friend (name)				
In case of emergency who should be notified? _____		Phone (_____) _____		

PRIMARY INSURANCE

Person Responsible for Account _____	Last Name _____	First Name _____	Middle Initial _____
Relation to Patient _____	Birthdate _____	ID#/Soc. Sec. # _____	
Address (If different from patient's) _____		Phone (_____) _____	
City _____	State _____	Zip _____	
Person Responsible Employed By _____		Occupation _____	
Business Address _____		Business Phone (_____) _____	
Insurance Company _____			
Contract # _____	Group # _____	Subscriber # _____	
Names of other dependents covered under this plan _____			

ADDITIONAL INSURANCE

Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Subscriber Name _____	Relation to Patient _____	Birthdate _____	
Address (If different from patient's) _____		Phone (_____) _____	
City _____	State _____	Zip _____	
Subscriber Employed by _____		Business Phone (_____) _____	
Insurance Company _____		Soc. Sec. # _____	
Contract # _____	Group # _____	Subscriber # _____	
Names of other dependents covered under this plan _____			

Please Complete Above Information and Next Page

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity to hot
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> Sensitivity to cold	<input type="checkbox"/> Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Cough up Blood	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Swelling of Feet or Ankles
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease

MEDICATIONS

List medications you are currently taking:

ALLERGIES

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____ Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Sign **X**

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.