

PATIENT REGISTRATION AND MEDICAL HISTORY

Date Home Phone Cell Phone

Patient Name Preferred Name

E-Mail Address

Street Address City State Zip

Gender: M F Age Birthdate Single Married Widowed Seperated Divorced

Employed by Occupation

Business Address Business Phone

Spouse Partner Name Spouse Birthdate

Spouse Employed by Occupation

Who is responsible for this account? Relationship to Patient

Social Security # Spouse's Social Security#

Dental Insurance Company Group Number

In case of emergency, who should be notified? Phone

Whom may we thank for referring you?

I understand that antibiotics may reduce the effectiveness of birth control pills. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. If I am delinquent in paying my account, I agree to pay interest on the overdue balance at a rate of 1.33% per month. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I understand that my health history information will be used as necessary for diagnosis or treatment. I authorize the use of this signature on all insurance submissions.

Signature Date

MEDICAL HISTORY

Have you or any member of your family seen this dentist previously? Yes No
If yes, which family member(s)

Date of last physical exam Physician's Name

Date of last dental exam Dentist's Name Date of last dental x-rays

Reason for leaving last dental office

CIRCLE

Yes No Are you having pain or discomfort at this time?

Yes No Is there anything you dislike about your smile?

Yes No Have you been under the care of a medical doctor during the past two years?

Yes No Have you ever had excessive bleeding requiring special treatment?