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General Dentistry

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305/661-7810

PATIENT REGISTRATION AND HEALTH HISTORY

Your kindness in furnishing the following confidential information will be appreciated:

Date: _____

Patient's Name: _____ Sex M / F Date of Birth: _____

If a child, Parent's Name: _____ Social Security #: _____

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ E-Mail Address _____

Employer: _____ How Long? _____

Business Address: _____

Occupation: _____ Business Phone: _____

Spouse's Name _____ Social Security#: _____

Employer: _____ How Long? _____ Date of Birth: _____

Business Address: _____

Occupation: _____ Business Phone: _____

In case of an emergency, name and address of nearest friend or relative not living with you:

_____ Phone: _____

Dental Insurance Company: _____ Policy: _____

Who can we thank for referring you to our office? _____

Were you referred to a specific doctor? ❑ Yes ❑ No If so, which one? _____

HEALTH HISTORY

1. Have you been treated by a physician or hospitalized during the last two years? ❑ Yes ❑ No
2. If so, what was the condition being treated? _____
3. Name of Physician _____ Phone # _____
4. Are you currently taking any medication? ❑ Yes ❑ No
5. If yes, please list _____
6. Are you allergic or have you reacted adversely to:

Latex	❑ Yes	❑ No	Local anesthetics (eg. novocaine)	❑ Yes	❑ No
Iodine	❑ Yes	❑ No	Penicillin	❑ Yes	❑ No
Codeine or other narcotics	❑ Yes	❑ No	Other Antibiotics	❑ Yes	❑ No
Foods (specify) _____			Sulfa Drugs	❑ Yes	❑ No
			Aspirin	❑ Yes	❑ No
			Any other medication _____		

7. Have you ever had any unfavorable experience associated with previous dental treatment? _____
8. Do you have any of the following conditions?

- ❑ Damaged or artificial heart valves
- ❑ Congenital heart defects
- ❑ Heart disease
- ❑ Stroke
- ❑ Mitral valve prolapse
- ❑ Heart murmur
- ❑ High blood pressure
- ❑ Pacemaker
- ❑ Rheumatic fever
- ❑ Artificial joints/pins or plates
- ❑ Chest pain
- ❑ Anemia
- ❑ Blood disorders
- ❑ Kidney trouble
- ❑ Kidney dialysis
- ❑ Stomach ulcers
- ❑ Hepatitis
- ❑ Liver disease
- ❑ Arthritis
- ❑ Diabetes
- ❑ Epilepsy or seizures
- ❑ Tuberculosis
- ❑ Glaucoma
- ❑ Fainting or dizzy spells
- ❑ Nervous disorder
- ❑ Venereal disease
- ❑ Acquired Immune Disorder
- ❑ Thyroid disease
- ❑ Radiation treatment
- ❑ Chemotherapy
- ❑ Growth or tumors
- ❑ Cancer
- ❑ Blood transfusions
- ❑ Abnormal or prolonged bleeding
- ❑ Allergies
- ❑ Asthma
- ❑ Emphysema or bronchitis
- ❑ Organ transplants
- ❑ Sinus trouble
- ❑ Cortisone treatment
- ❑ Any major operations
- ❑ Any other serious illness
- ❑ Psychiatric treatments
- ❑ Surgical implants
- ❑ Smoker
- ❑ Chew tobacco

9. Female Patients:
   a. Are you pregnant? ❑ Yes ❑ No
   b. If yes, what month? _____
   c. Are you nursing? ❑ Yes ❑ No

To the best of my knowledge, the foregoing questions have been accurately answered.

I, the undersigned, being the patient or guardian of the above mentioned patient, consent to the administration of a local anesthetic in conjunction with dental treatment.

I grant the right to release health information obtained from me, and information about my dental treatment to third party payers and/or other health practitioners.

Patient's/Parent's Signature _____ Date _____

Reviewed by _____

(over)

FINANCIAL POLICY

"Our financial policy was designed to give you a number of payment options to choose from in order to make your health care payment as easy on you as we can. You will receive important forms that must be completed prior to seeing the doctor. In order to provide the highest quality of care, please complete these forms as accurately as you can.

Regarding insurance, at the time of service we require certain co-payment or deductible amounts depending on the type of insurance carrier. For this you may use cash, check or credit card. If the remaining balance (estimated insurance payment has not been paid within 45 days, we request that you pay this balance using one of the above payment method."

As part of our continued effort to provide you with the highest quality of dental care, we may elect to place a tooth colored bonded composite restoration in your tooth instead of the more traditional silver amalgam filling. We feel that this restoration is beneficial due to the strength of the chemical bond, as well as being more esthetically pleasing. Your insurance company may not recognize these benefits and may pay only based on the less costly silver amalgam; thereby making you responsible for the difference. Please remember that we only have your best interest in mind. If you have any questions, please feel free to communicate them to your doctor. We know our patients will cooperate with this financial policy. If you have any questions regarding the above, please do not hesitate to ask.

DENTAL FEE IS PAYABLE AT THE TIME OF SERVICES RENDERED.

Date:_____ SSN:_____

Please mark method of payment:

Cash:_____ Credit Card:_____ Check:_____

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

SIGNATURE:_____

Medical history reviewed:

Date: _____

Reviewed by _____

Medical history reviewed:

Date: _____

Reviewed by _____

Medical history reviewed:

Date: _____

Reviewed by _____

Medical history reviewed:

Date: _____

Reviewed by _____

Medical history reviewed:

Date: _____

Reviewed by _____

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Reviewed by _____