PATIENT REGISTRATION

Welcome! So that we may provide you with the best possible care, please complete all questions on this form. All information is completely confidential.

PATIENT NAME _____ DATE _____

IF MINOR, NAME OF PARENT OR GUARDIAN _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ BUSINESS PHONE # _____

CELL # _____ EMAIL ADDRESS _____

SOCIAL SECURITY # _____ BIRTH DATE _____ AGE _____

EMPLOYER _____

PRESENT POSITION _____ HOW LONG HELD _____

PATIENTS DENTAL INSURANCE CO. _____

BIRTHDATE OF INSURED _____ SOCIAL SECURITY # OF INSURED _____

SPOUSE NAME _____

SPOUSE EMPLOYER _____ BUSINESS PHONE _____

IN CASE OF EMERGENCY CONTACT _____ PHONE # _____

CLOSE RELATIVE NOT LIVING WITH YOU _____ PHONE # _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT _____

WHOM MAY WE THANK FOR REFERRING YOU _____

HEALTH HISTORY

Physician's Name_____ Date of last physical exam_____

Please list any known drug allergies : _____

Circle any of the following which you have had or have at present:

Heart Disease or Attack	Sleep Apnea	Hepatitis A (infectious)	
Tuberculosis (TB)	Hepatitis B (serum)	Kidney Trouble	Angina Pectoris
High Blood Pressure	Asthma	Liver Disease	Ulcers
Stroke	Migraines	Epilepsy or Seizures	Nervousness
Sinus Trouble	Fainting or Dizzy Spells	Emphysema	Anemia
Congenital Heart Lesions	Arthritis	Drug Addiction	Glaucoma
Heart Surgery	Diabetes	Hemophilia	Pain in Jaw
Artificial Heart Valve	Thyroid Disease	Cold Sores/Fever Blisters	Depression
Heart Pacemaker	Radiation/X-Ray Treatment	Sickle Cell Disease	A.I.D.S./H.I.V.
Artificial Joint (Hip, Knee)	Chemotherapy	Bruise Easily	

Do you have any disease, condition, or problem not listed?_____

Are you under the care of a physician?_____ Physician's Name_____

If yes, for what reason?_____

Have you ever taken any bone replacement or osteoporosis medications? (ex. Fosamax, Aredia, Zometa). If yes, what medication?_____

What medications are you currently taking and for what reason? _____

For women only: Are you pregnant?_____ If yes, what month?_____ Are you taking birth control pills?_____

Health History Update _____ _____ _____ _____ _____ _____

The above information is correct and complete to the best of my knowledge. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% (18% APR) may be added to my account. Should this account be sent for collection, those collection fees may be added to the outstanding balance.

Signature (parent if minor)_____