# REGISTRATION FORM

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| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | | | | | | | PCP: | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | First: | | | | | | | | Middle: | | | | ❑ Mr.  ❑ Mrs. | | | ❑ Miss  ❑ Ms. | | | | | Marital status (circle one) | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | | |
| Is this your legal name? | | | | If not, what is your legal name? | | | | | | | | | | | | | (Former name): | | | | | | | | | | Birth date: | | | | | | Age: | | | Sex: | | |
| ❑ Yes | ❑ No | | |  | | | | | | | | | | | | |  | | | | | | | | | | / / | | | | | |  | | | ❑ M | | ❑ F |
| Street address: | | | | | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | | Home phone no.: | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | ( ) | | | | | | | |
| P.O. box: | | | | | | | | | City: | | | | | | | | | | | | | | | | State: | | | | | | | ZIP Code: | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | |
| Chose clinic because/Referred to clinic by  (please check one box): | | | | | | | | | | | | | | | | | |  | | |  | | | | | |  | | | | | | | |  | | | |
| ❑ Family | | ❑ Friend | | | | | | | ❑ Internet | | | | | | | ❑ Yellow Pages | | | | | | | | | | | | | ❑ Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| ❑ Patient | | ❑ Brochure | | | | | | | ❑ Hospital | | | | | | | ❑ Insurance Plan | | | | | | | | | | | | | ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Other family members seen here: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | Birth date: | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | |
|  | | | | | / / | | | | | | | |  | | | | | | | | | | | | | | | | | ( ) | | | | | | | | |
| Is this person a patient here? | | | | | ❑ Yes | | | | | ❑ No | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Occupation: | | | Employer: | | | | | | | Employer address: | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | |
|  | | |  | | | | | | |  | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | |
| Is this patient covered by insurance? | | | | | | | | | ❑ Yes | | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate primary insurance | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Subscriber’s name: | | | | | | Subscriber’s S.S. no.: | | | | | | | | | Birth date: | | | | | | | Group no.: | | | | | | | | Policy no.: | | | | | | | Co-payment: | |
|  | | | | | |  | | | | | | | | | / / | | | | | | |  | | | | | | | |  | | | | | | | $ | |
| Patient’s relationship to subscriber: | | | | | | | ❑ Self | | | | | | | ❑ Spouse | | | | ❑ Child | | | | ❑ Other | | | | | |  | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | Group no.: | | | | | | Policy no.: | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | |  | | | | |
| Patient’s relationship to subscriber: | | | | | | | | ❑ Self | | | | | | ❑ Spouse | | | | ❑ Child | | | | ❑ Other | | | | | |  | | | | | | | | | | |

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| CONSENT FOR SERVICES | | |
| As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.  All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.    Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.  I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.  In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.  I grant my permission to your assignee to telephone me at home or at my work to discuss matters related to this form. | | |
| Signature of patient, parent or guardian | Relationship to patient: | Date: |
|  |  | / / |
| Signature of patient, parent or guardian | Relationship to patient: | Date: |
|  |  | / / |
| Signature of patient, parent or guardian | Relationship to patient: | Date: |
|  |  | / / |

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| --- | --- | --- |
| Have you ever had any of the following? Please check all those that apply | | |
| ❑ AIDS / HIV | ❑ Growths | ❑ Respiratory Problems |
| ❑ Allergies (list in box below) | ❑ Hay Fever | ❑ Rheumatic Fever |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Head Injuries | ❑ Rheumatism |
| ❑ Anemia | ❑ Heart Disease | ❑ Sinus Problems |
| ❑ Arthritis | ❑ Heart Murmur | ❑ Stomach Problems |
| ❑ Artificial Joint | ❑ Hepatitis | ❑ Stroke |
| ❑ Asthma | ❑ High Blood Pressure | ❑ Tuberculosis |
| ❑ Blood Disease | ❑ Jaundice | ❑ Tumors |
| ❑ Cancer | ❑ Kidney Disease | ❑ Ulcers |
| ❑ Diabetes | ❑ Liver Disease | ❑ Venereal Disease |
| ❑ Dizziness | ❑ Mental Disorders | ❑ Codeine Allergy |
| ❑ Epilepsy | ❑ Nervous Disorders | ❑ Penicillin Allergy |
| ❑ Excessive Bleeding | ❑ Pacemaker | ❑ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❑ Fainting | ❑ Pregnancy  Due Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| ❑ Glaucoma | ❑ Radiation Treatment |  |

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| --- | --- | --- |
| Have you ever had any complications following dental treatment? | ❑ Yes | ❑ No |
| If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Have you ever been admitted to a hospital or needed emergency care during the past two years? | ❑ Yes | ❑ No |
| If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Are you now under the care of a physician? | ❑ Yes | ❑ No |
| If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Do you have any health problems that need further clarifications? | ❑ Yes | ❑ No |
| If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **ACKNOWLEDGEMENT** | | |
| To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. | | |
| Signature of patient, parent or guardian | Relationship to patient: | Date: |
|  |  | / / |

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| **ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES** | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been offered a copy of this office’s Notice of Privacy Practices.  (Please Print Name) | | |
| Signature of patient, parent or guardian | Relationship to patient: | Date: |
|  |  | / / |
| Signature of Doctor | | Date: |
|  | | / / |