

Dr. Rhonda F. Company, D.D.S., Inc. & Associates
PATIENT REGISTRATION AND MEDICAL HISTORY

Patient Information

(PLEASE PRINT)

Date _____ Home Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse Name _____ Spouse Birthdate _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

If patient is child what is his/her weight? _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

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

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic/Scarlet fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease or malfunction | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Material allergies (latex, wool metal, chemicals) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pacemaker/Heart surgery | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Cancer | Describe _____ | <input type="checkbox"/> Rapid weight gain or loss | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hemophilia/Abnormal bleeding | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Circulatory problems | | | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cortisone treatments | | | |

continued other side

List medications you are currently taking, including herbs & vitamins _____

List drug allergies, if any: _____

Is there anything else we should know about your medical history? _____

Do you have dental insurance coverage? Yes No

PRIMARY INSURANCE

Person responsible for account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec.# _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contact # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Married Single Widowed Separated Divorced

ADDITIONAL INSURANCE

If patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Phone _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Married Single Widowed Separated Divorced

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

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

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Date *Signature*

Date *Doctor's Signature*

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Signature

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Doctor's Signature

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