Rhonda F. Company DDS, Andrea M. Company DDS & Associates

PATIENT REGISTRATION AND MEDICAL HISTORY

Patient Information

(PLEASE PRINT)

Date _____ Home Phone _____ Cell 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:

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

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 pây 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.