PATIENT REGISTRATION

Patient Name:	Drivers License:	Marital Status:
		S M D W

Address:	Birth Date:	Sex:	Social Security No.
		M F	

City State Zip:	Email:

Home Phone:	Work Phone:	Cell Phone:

Primary Insured/Responsible Party:	Relationship to Patient:	Insured's Date of Birth:	Insured's Social Security No.

Insured's Employer:	Primary Insurance Co.	Insurance Phone No.

Secondary Insured/Responsible Party:	Relationship to Patient:	Insured's Date of Birth:	Insured's Social Security No.

Insured's Employer:	Secondary Insurance Co.	Insurance Phone No.

Emergency Contact Name:	Home Phone:	Cell or Work Phone:

MEDICAL HISTORY

Abnormal Bleeding	Y N	Heart Failure	Y N	Scarlet Fever	Y N
Alcohol Addiction	Y N	Heart Murmur	Y N	Seizures	Y N
Anemia	Y N	Heart Trouble	Y N	Sickle Cell Disease	Y N
Angina/Chest Pain	Y N	Hemophilia	Y N	Sinus Problems	Y N
Artificial Heart Valve	Y N	Hepatitis A	Y N	Stomach/Intestinal Disease	Y N
Artificial Joint	Y N	Hepatitis B	Y N	Stroke	Y N
Asthma	Y N	Hepatitis C	Y N	Thyroid Problems	Y N
Blood Transfusion	Y N	High Blood Pressure	Y N	Tuberculosis	Y N
Breathing Problem	Y N	HIV+ AIDS	Y N	Tumors/Growths	Y N
Bruise Easily	Y N	Hypoglycemia	Y N	Venereal Disease/Genital Herpes	Y N
Cancer	Y N	Kidney Problems	Y N	Allergies	
Chemotherapy	Y N	Liver Disease	Y N	Aspirin	Y N
Congenital Heart Defect	Y N	Low Blood Pressure	Y N	Codiene	Y N
Convulsions	Y N	Lung Disease	Y N	Dental Anesthetics	Y N
Cortisone Medicine	Y N	Mitral Valve Prolapse	Y N	Erythromycin	Y N
Diabetes	Y N	PRE MED	Y N	Jewelry	Y N
Drug Addiction	Y N	Pace Maker	Y N	Latex	Y N
Emphysema	Y N	Pain in Jaw Joints	Y N	Metals	Y N
Epilepsy	Y N	Psychiatric Problems	Y N	Penicillin	Y N
Excessive Thirst	Y N	Radiation	Y N	Tetracycline	Y N
Fainting/Dizziness	Y N	Recent Weight Loss	Y N	Other	
Heart Attack	Y N	Renal Dialysis	Y N		
Heart Disease	Y N	Rheumatic Fever	Y N		

Primary Care Physician:	Phone:
Preferred Pharmacy:	Phone:

Do you smoke or use tobacco? Y N	(WOMEN ONLY)	Are you taking Birth Control Pills? Y N
	Are you nursing? Y N	Are you pregnant? Y N # of weeks _____

List Current Medications:

Is there any disease, condition or problem that you think this office should know about that is not covered above? Y N
If yes, please describe below...

Whom may we thank for referring you to our office?

AUTHORIZATION

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. Insurance benefits are not a guarantee of payment. Patient copays are estimated and I am responsible for any unpaid balance. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and patient registration are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals. I am aware that a copy of the office HIPAA policy is available upon request and on our website www.smilelovers.com.

METHOD OF PAYMENT

Payment in full is expected as services are rendered. Our office accepts cash, check, debit and all major credit cards. Financing is available upon approval. Applications for financing are available at the front desk.

Signature:_____Date:_____

Patient or Responsible Party (If Under 18, Parent or Guardian Required)