

Patient Registration

Patient Information

Patient Name: _____ Date of Birth: _____
 Patient Address: _____ Social Security #: _____
 City/State/Zip: _____
 Home Phone: _____
 Work Phone: _____ Employer: _____
 Mobile Phone: _____ Married ___ Single ___ Child ___
 E-mail: _____ Female ___ Male ___

*Please indicate your preference for contact: email or phone (circle one).

Medical History

Have you had any of the following? Please check those that apply:

<input type="checkbox"/>	Any Heart Problems	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Fainting / Epilepsy
<input type="checkbox"/>	High Blood pressure	<input type="checkbox"/>	Malignancies	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	HIV/ AIDS
<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	Artificial Valves	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Artificial Joints
<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Pregnancy

Are you allergic to any drugs? _____

Are you currently under the care of a physician? _____

If yes, please explain: _____

Name of the physician and phone #: _____

Do you have any health problems that need further clarification? _____

If yes, please explain: _____

Patient Registration (Cont.)

Dental History

Date of last dental visit: _____ Reason for this visit: _____

Do you have a history of:

_____ Gum Disease _____ Abscesses _____ Ulcers
_____ Grinding Teeth _____ Clicking of TMJ _____ Sensitivities

Do you require Antibiotic pre-medication? _____

Referral Information

How did you learn about our practice?

_____ Another Patient _____ Another Doctor _____ Web search _____ Advertisement

Please provide details: _____

Policy Holder Information

Name: _____ Relation: _____

Date of Birth: _____ SS#: _____

Address: _____ Phone (Home): _____

City/State/Zip: _____ Phone (Work): _____

Employer: _____ Dental Insurance: _____

Employer Address: _____ Group#: _____

City/State/Zip: _____

Payment Method: ___ Cash ___ Check ___ Credit Card # _____

Consent for Services

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at time of visit. Patient is solely responsible for any balance not paid by their insurance company. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize Downtown Dental Design to release any information to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ **Date:** _____