**PATIENT REGISTRATION**

Date: Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Best number to reach you about appointments? : Home or Cell Can we email or text you for appointments? Yes or No

Patient: Marital Status:
 Last Name First Name Middle Initial

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Mailing Address: City: State: Zip Code:
Sex: M F Age: Birth Date: S.S. #
Employer: Employer Phone:
Spouse Name: Spouse’s Employer: Employer Phone:
Closest relative not living with you: Phone:
Whom may we thank for referring you?
Who is your General Dentist?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which pharmacy do you use?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**MEDICAL HISTORY**

Physician’s Name: Date of Last Physical:

Have you ever had any of the following?

Yes No Yes No Yes No

\_\_\_ \_\_\_ Heart Problems \_\_\_ \_\_\_ Sinus Problems \_\_\_ \_\_\_ Nervous Problems

\_\_\_ \_\_\_ Artificial Heart Valves \_\_\_ \_\_\_ Stroke \_\_\_ \_\_\_ Psychiatric Care
\_\_\_ \_\_\_ Artificial Joints \_\_\_ \_\_\_ Blood disease \_\_\_ \_\_\_ Chemical Dependency

\_\_\_ \_\_\_ Rheumatic Fever, Murmur \_\_\_ \_\_\_ Bleeding Disorder \_\_\_ \_\_\_ Back Problems

\_\_\_ \_\_\_ High Blood Pressure \_\_\_ \_\_\_ Hepatitis, Jaundice \_\_\_ \_\_\_ Arthritis

\_\_\_ \_\_\_ Shortness of Breath or Liver Disease \_\_\_ \_\_\_ Venereal Disease

\_\_\_ \_\_\_ Circulatory Problems \_\_\_ \_\_\_ Kidney Disease \_\_\_ \_\_\_ AIDS / Other Immuno-

\_\_\_ \_\_\_ Lung Disorder \_\_\_ \_\_\_ Chronic Diarrhea suppressive Disorder

\_\_\_ \_\_\_ Asthma \_\_\_ \_\_\_ Ulcer \_\_\_ \_\_\_ Allergies to Anesthetic

\_\_\_ \_\_\_ Thyroid Disease \_\_\_ \_\_\_ Diabetes \_\_\_ \_\_\_ Allergies to Medicines

\_\_\_ \_\_\_ Epilepsy \_\_\_ \_\_\_ Special Diet or Drugs

\_\_\_ \_\_\_ Headaches \_\_\_ \_\_\_ Recent Weight Loss \_\_\_ \_\_\_ General Allergies

\_\_\_ \_\_\_ Swollen Neck Glands \_\_\_ \_\_\_ Cancer \_\_\_ \_\_\_ Sleep Apnea (use

\_\_\_ \_\_\_ Radiation Treatment CPAP)

Do you have any drug allergies or have you ever had any adverse reaction to any medication? If so, please explain

Have you ever responded adversely to medical or dental treatment?

List all current medications and supplements you are taking, if you are not taking any please write N/A?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications for osteoporosis such as Bisphosphonates? (i.e. Zometa, Aredia, Fosamax, Actonel, Boniva)

 Yes No If Yes, Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was taken by IV\_\_\_\_\_\_\_ or by Oral \_\_\_\_\_\_\_?

Are you under the care of a physician? \_\_\_ Yes \_\_\_ No For what condition?

Do you use tobacco? \_\_\_Yes \_\_\_ No If yes: do you \_\_\_ *Smoke(cigarettes) or \_\_\_\_use Smokeless (*Chewing tobacco) Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you Vape? \_\_\_\_\_Yes \_\_\_\_No

Female Patients: Do you suspect that you are pregnant? Yes No Trimester Are you nursing? Yes No

**PERSON RESPONSIBLE FOR PAYMENT**If you are a **parent bringing a minor**, the signer of the registration and financial agreement will be listed as the responsible party.
(If you are **18 years** **of age** or older **you** are the person responsible and signing all forms.)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle one (Self, Parent, Legal Guardian)

P.O. Box /
Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cellular / Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_

Responsible Party’s Driver’s License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**Medical / Dental Insurance** is a contract between the insured and the insurance carrier. The patient is responsible to our office for the total fees charged for services rendered. We are happy to bill your insurance company as a service to you if you supply us with the necessary information.

**Primary** Medical / Dental (Circle One) **Secondary** Medical / Dental (Circle One)

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth of Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID.#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID.#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insur Co Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insur Co. Address.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information on this form is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors of omission that I may have made in completing the form.

I have read and / or been furnished with a copy of the “Notice of Privacy Practices” for Southwest Oral Surgical Arts.

I agree to pay in full all fees that are incurred during my dental treatment or treatment of the above patient. I also understand that I am responsible for any balance not paid by my insurance company.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date Parent / Guardian’s Signature Date