

# PATIENT REGISTRATION AND MEDICAL HISTORY

Date \_\_\_\_\_ (please print) Home Phone (\_\_\_\_) \_\_\_\_\_

Patient \_\_\_\_\_  
Last Name First Name Middle Initial Preferred Name

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_ M \_\_\_ F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ \_\_\_ Married \_\_\_ Widowed \_\_\_ Single \_\_\_ Minor  
\_\_\_ Separated \_\_\_ Divorced

Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School Phone \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_ Spouse/Parent Birthdate \_\_\_\_\_

Spouse/Parent Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Who is the guarantor of this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse/Parent's Social Security # \_\_\_\_\_

Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

In case of emergency, who should we notify? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Medical History

Physician's Name \_\_\_\_\_ Physician's Phone Number \_\_\_\_\_

Have you ever had any of the following? (check all that apply)

<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Artificial Heart Valves, Joints, Screws, etc	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Bleeding Abnormally	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Special Diet
<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Stroke
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Swollen Neck Glands
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Venereal Disease

Do you have any drug allergies or ever had an adverse reaction to any medication or anesthesia? \_\_\_ Yes \_\_\_ No

If so, what? \_\_\_\_\_

Have you ever responded adversely to medical or dental treatment? \_\_\_ Yes \_\_\_ No

Are you taking any medication at this time? \_\_\_\_\_ If so, what? \_\_\_\_\_

Are you under the care of a physician? \_\_\_ If so, for what conditions? \_\_\_\_\_

Date of your last physical \_\_\_\_\_

If patient is a child, what is his/her weight? \_\_\_\_\_

(Women) Do you suspect that you are pregnant? \_\_\_ Yes \_\_\_ No Due Date \_\_\_\_\_

(Women) Are you nursing? \_\_\_ Yes \_\_\_ No Taking Birth Control Pills \_\_\_ Yes \_\_\_ No

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

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## **CERTIFICATION**

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To the best of my knowledge, the information provided on this form is complete and correct.

I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

## **MINOR/CHILD CONSENT**

I am the parent, guardian, or personal representative of \_\_\_\_\_  
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child/minor named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not

I am present when the treatment is rendered.

## **INSURANCE ASSIGNMENT AND RELEASE**

I certify that my dependent(s) is covered by insurance with \_\_\_\_\_  
Name of Insurance Company(ies)

and **assign directly to Dr. Chomas all insurance benefits**, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

## **FINANCIAL AGREEMENT**

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

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Signature of Parent, Guardian or Personal Representative

Date

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Please Print Name of Parent, Guardian or Personal Representative

Relationship to Patient