REGISTRATION FORM / MEDICAL HISTORY

Dr. Mr. Mrs. Miss Ms. Today's Date_____

Name: _____ Phone # - Home: _____
Address: _____ Office #: _____
City/State/Zip:_____ Cell #_____
Occupation: _____ E-mail _____
Referring Dentist: _____

Patient Social Security #: _____ Patient Date of Birth:_____

Dental Ins. _____ Name of Subscriber _____

Patient Relationship to Subscriber _____ Subscriber SS# /I.D. #_____

Group No. _____ Employer _____ Subscriber Date of Birth _____

Do you have, or have you had any of the following?

Mitral Valve Prolapse	Yes No		
Heart Murmur	Yes No	Hepatitis	Yes No
Rheumatic Fever	Yes No	Diabetes	Yes No
Angina	Yes No	Glaucoma	Yes No
Arteriosclerosis	Yes No	Venereal Disease	Yes No
High Blood Pressure	Yes No	Asthma	Yes No
Low Blood Pressure	Yes No	Urinary Infection	Yes No
Anemia	Yes No	Kidney Disease	Yes No
Bleeding Problems	Yes No	Ulcers	Yes No
Liver Disease	Yes No	Cancer	Yes No
Thyroid Disease	Yes No	Radiation	Yes No
Lung Disease	Yes No	Chemotherapy	Yes No

1. Are you presently under the care of a physician? Yes No
   If so, what for? _____

2. Are you presently taking any drug or medication? Yes No
   If so, please list them _____
   _____

3. Do you require pre-medication with antibiotics for dental procedures? Yes No
4. Are you taking aspirin for any reason? Yes No
5. Do you have damaged or artificial heart valves? Yes No
6. Do you have an artificial hip or other prosthetic device? Yes No
7. Do you have a cardiac pacemaker? Yes No
8. Do you experience chest pain upon exertion? Yes No
9. Do you have heart trouble or cardiovascular disease? Yes No
10. Are you ever short of breath after mild exercise? Yes No

Complete on Reverse Side

Pregnant? Yes No Nursing: Yes No

Please circle any of the following drugs to which you may be allergic:

Penicillin
Erythromycin
Other Antibiotics
Aspirin
Ibuprofen (Motrin, Advil)
Codeine
Novocaine
Adrenaline
Other allergies? _____

Name and Address of Physician: _____
_____
_____

FEDERAL TRUTH IN LENDING STATEMENT FOR PROFESSIONAL SERVICES RENDERED

1. The collection of monies from your insurance company is ***YOUR*** responsibility. We will, however, submit to your insurance company for your reimbursement.

2. You are ***personally*** responsible for
    1. ANY DEDUCTIBLE
    2. CO-PAYMENT (what your insurance company makes you responsible for and which is deducted from their payment)
    3. Should your account be sent to collection, you will be additionally responsible for:
        1. Attorneys fees which are 1/3 of the balance due and 1/3 of any interest and costs expended in the prosecution of the matter.

SIGNATURE: _____ **DATE:** _____