PATIENT REGISTRATION AND MEDICAL HISTORY

Date	(PLEAS	SE PRINT)	Home Phor	ne ()		
Patient	First Name		Middle Initial		Preferred Name	
Street Address					Zip	
E-mail						
Sex M F Age Birthdate			/ Widowed		The state of the s	
OCK III II Age III BII III III II II II II II II II II				_	Minor	
5-1-0-0-1-1		Separated	Divorced		d for years	
Employer/School						
Employer/School Address						
Spouse/Parent Name						
Spouse/Parent Employed by						
Business Address		Business Phone ()				
Who is responsible for this account?		Relationship to Patient				
Social Security #						
Name of Dental Insurance Company						
In case of emergency, who should be notified?						
Whom may we thank for referring you?						
				-		
	MEDICA	L HISTORY			4.	
Physician's Name			_ Date of Last Ph	ysical		
Have you ever had any of the following? (check box	es that apply):					
Allergies				☐ Pacemaker		
Arthritis	Headaches			☐ Psychiatric Care		
☐ Artificial Heart Valves or Joints, Screws, etc	☐ Heart Murm			Radiation Treatment		
Back Problems	☐ Heart Problems			Recent Weight Loss		
☐ Bleeding Abnormally ☐ Blood Disease	☐ Hemophilia			☐ Respiratory Disease		
☐ Cancer	☐ Hepatitis, Jaundice or Liver					
Chemical Dependency	☐ Hernia Repair			☐ Sinus Problems		
Chronic Diarrhea	☐ High Blood Pressure			□ Special Diet		
	☐ HIV/AIDS			☐ Stroke		
Circulatory Problems	Low Blood Pressure			Swollen Neck Glands		
Congenital Heart Lesions	☐ Mitral Valve Prolapse			Ulcer		
Diabetes	☐ Nervous Pro	polems		☐ Venereal Dis	ease	
Do you have any drug allergies or have you ever had	d an adverse react	ion to any medica	tion or anesthesia?	☐ Yes ☐ No		
If so, what?						
Have you ever responded adversely to medical or de					-	
Are you taking any medication at this time?						
Have you ever taken any of the group of drugs colle (brand names of phentermine), Pondimin (fenfluration)				inations of Ionir	nin, Adipex, Fastin	
Are you under the care of a physician? \square Yes \square N	For what conditions?					
If patient is a child, what is his/her weight?					£ .	
(Women) Do you suspect that you are pregnant?	Yes No	Due date				
Are you nursing? ☐ Yes ☐ No			Taking birth control pills? ☐ Yes ☐ No			
Is there anything else we should know about your n	nedical history?					

CERTIFICATION

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.

MI	INOR/CHILD CONSENT
I am the parent, guardian, or personal representative	e of Please Print Name of Minor/Child
and there are no court orders now in effect that proh to perform necessary dental services for the child n which are deemed advisable by the doctor, whether o	nibit me from signing this consent. I do hereby request and authorize the dental staff named above, including but not limited to x-rays, and administration of anesthetics.
	CE ASSIGNMENT AND RELEASE
I certify that my dependent(s) is covered by insurance	Name of Insurance Company(ies)
	Name of Insurance Company(ies)
and assign directly to Dr. otherwise payable to me for services rendered. I uninsurance. I authorize the use of my signature on all	all insurance benefits, if any, inderstand that I am financially responsible for all charges whether or not paid by insurance submissions.
Insurance Company(ies) and their agents for the pu	's health care information and may disclose such information to the above-named urpose of obtaining payment for services and determining insurance benefits or the will end when the current treatment plan is completed or one year from the date
FI	NANCIAL AGREEMENT
personal representatives are responsible for all fe	treatment, unless other arrangements are made. I agree that parents, guardians or sees and services rendered for treatment of a minor/child. I accept full financia provided to me or the patient. I understand that filing a claim with my insurance of for the payment of all charges.

Signature of Parent, Guardian or Pers	sonal Representative Date
Please print name of Parent, Guardian or	Personal Representative Relationship to Patient
MEI	DICAL HISTORY UPDATE
las there been any change in the patient's health sind	ce the last dental appointment? Yes No
or what conditions?	
the patient taking any new medications?	If so, what?
Date	Patient Signature
Date	Dentist Signature
ME	DICAL HISTORY UPDATE
	and the second of the second s
as there been any change in the patient's health sind or what conditions?	
**	If so, what?
Date	Patient Signature
Date	Dentist Signature