

## PATIENT REGISTRATION

Patient Name:		Drivers License:		Marital Status:	
				S M D W	
Address:		Birth Date:	Sex:	Social Security No.	
			M F		
City State Zip:		Email:			
Home Phone:		Work Phone:		Cell Phone:	
Primary Insured/Responsible Party:		Relationship to Patient:		Insured's Date of Birth:	
Insured's Employer:		Primary Insurance Co.		Insurance Phone No.	
Secondary Insured/Responsible Party:		Relationship to Patient:		Insured's Date of Birth:	
Insured's Employer:		Secondary Insurance Co.		Insurance Phone No.	
Emergency Contact Name:		Home Phone:		Cell or Work Phone:	

## MEDICAL HISTORY

Do you smoke or use tobacco? Y N	<b>(WOMEN ONLY)</b>	Are you taking Birth Control Pills? Y N
	Are you nursing? Y N	Are you pregnant? Y N # of weeks _____

Abnormal Bleeding	Heart Failure	Scarlet Fever
Alcohol Addiction	Heart Murmur	Seizures
Anemia	Heart Trouble	Sickle Cell Disease
Angina/Chest Pain	Hemophilia	Sinus Problems
Artificial Heart Valve	Hepatitis A	Stomach/Intestinal Disease
Artificial Joint	Hepatitis B	Stroke
Asthma	Hepatitis C	Thyroid Problems
Blood Transfusion	High Blood Pressure	Tuberculosis
Breathing Problem	HIV+ AIDS	Tumors/Growths
Bruise Easily	Hypoglycemia	Venereal Disease/Genital Herpes
Cancer	Kidney Problems	<b>Allergies</b>
Chemotherapy	Liver Disease	Aspirin
Congenital Heart Defect	Low Blood Pressure	Codiene
Convulsions	Lung Disease	Dental Anesthetics
Cortisone Medicine	Mitral Valve Prolapse	Erythromycin
Diabetes	PRE MED	Jewelry
Drug Addiction	Pace Maker	Latex
Emphysema	Pain in Jaw Joints	Metals
Epilepsy	Psychiatric Problems	Penicillin
Excessive Thirst	Radiation	Tetracycline
Fainting/Dizziness	Recent Weight Loss	Other
Heart Attack	Renal Dialysis	
Heart Disease	Rheumatic Fever	

Primary Care Physician:	Phone:
Preferred Pharmacy:	Phone:

**List Current Medications:**


Is there any disease, condition or problem that you think this office should know about that is not covered above?    Y    N  
If yes, please describe below...


Whom may we thank for referring you to our office?

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**AUTHORIZATION**

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. Insurance benefits are not a guarantee of payment. Patient copays are estimated and I am responsible for any unpaid balance. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and patient registration are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals. I am aware that a copy of the office HIPAA policy is available upon request and on our website [www.smilelovers.com](http://www.smilelovers.com).

**METHOD OF PAYMENT**

Payment in full is expected as services are rendered. Our office accepts cash, check, debit and all major credit cards. Financing is available upon approval. Applications for financing are available at the front desk.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Responsible Party (If Under 18, Parent or Guardian Required)