

Patient Registration

W. Mark Donald, DMD, MAGD

PATIENT INFORMATION (Confidential)

*Required Fields

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us--We will be happy to help.

Patient First Name:

Patient Middle Name:

Patient Last Name:*

Address:*

City:*

State:*

Zip Code:*

Home Phone#:

Work Phone#:

Cell Phone#:

Email Address:

Social Security#:

Check Appropriate Box:

Minor

Single

Married

Patient's or Parents Employer

Spouse or Parent's Name:

Employer:

Person to Contact in Case of Emergency:

Phone#:

RESPONSIBLE PARTY

Name of Person Responsible
for this Account:

Relationship to Patient:

Birthdate:

Address:

Home Phone#:

Social Security#:

PLEASE GIVE FRONT DESK A COPY OF INSURANCE CARD AND A PICTURE ID!

We file dental insurance as a courtesy to you. We will file Primary insurance only, but we will assist you in filing your Secondary insurance. At each visit, we will estimate your deductible and percentage to be paid that day. Please remember that insurance coverage is between the company and the individual. We will do our best to estimate what your insurance will pay, but you are ultimately responsible for your account. If your insurance has not paid in 60 days then you are to pay the balance. We will be sending monthly statements to allow you to keep up with the progress of your insurance.

Signature: *

Sign

Date:*

PATIENT MEDICAL HISTORY

Last Dentist:

Date of last cleaning:

Physician:

Office Phone:

Yes **No**

Are you under medical treatment now?

Have you ever been hospitalized for any surgical operation or serious illness?

Do you use tobacco?

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

Are you taking any medication(s). Including non-prescription medicine

Yes

No

If Yes, what medication are you taking?:

Are you allergic to or have you had any reactions to the following?

Yes **No**

Local Anesthetics (eg. Novocaine)

Penicillin or other Antibiotics

If Other, please mention:

- | | | |
|--------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

WOMEN ONLY:

- | | Yes | No |
|--|--------------------------|--------------------------|
| Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have or have you had any of the following? Select the ones that apply:

- | | |
|--|---|
| <input type="checkbox"/> AIDS or HIV infection | <input type="checkbox"/> Hepatitis/Jaundice |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Joint Replacement or Implant |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Emphysema | |

Other (please specify):

- | | |
|---|---|
| <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Other |

Has your Medical Physician ever said you needed Pre-Medication for any reason?

- Yes
 No

Please mention reason why?:

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents. I authorize the dentist to use my dental photos of my procedures for educational and/or marketing purposes if needed.

Signature: *

Sign

Date:*
