Patient Registration

First Name:_____ Last Name:_____ Middle Initial:_____
Patient is: ○ Policy Holder ○ Responsible Party Preferred Name:_____

Patient Information
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Ext._____ Cell:_____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorce ○ Separated ○ Widowed
Birth Date: _____ Age: _____ Soc Sec:_____ Drivers License:_____
E-Mail:_____ ○ I would like to receive correspondences via e-mail.

Responsible Party

First Name:_____ Middle Initial:_____ Last Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Ext._____ Cell:_____
Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorce ○ Separated ○ Widowed
Birth Date: _____ Age: _____ Soc Sec:_____ Drivers License:_____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Employment Status

○ Full Time ○ Part Time ○ Retired
Student Status
○ Full time ○ Part Time
Previous Dentist Name
_____

Emergency Contact

First Name_____ Last Name_____
Contact number _____
Who may we thank for referring you to our office?
_____

*Please keep in mind in order to retrieve your benefits and bill your insurance on your behalf you will need to provide one of the following. You will need to provide Elevated Smiles your ***member Identification number*** or your ***social security number*** along with date of birth of the policy holder**.** Most insurance will issue a card, however you may call your insurance carrier and ask for an alternate Identification number.

Primary Insurance

Name insured: _____ Date of Birth: _____

Relationship to insured: ○ Self ○ Spouse ○ Child ○ Other
Member Identification_____
Soc Sec Number:_____
Employer Name:_____
Ins Co:_____
Ins Gp Number:_____
Ins Phone Number:_____

Secondary Insurance

Name insured: _____ Date of Birth: _____

Relationship to insured: ○ Self ○ Spouse ○ Child ○ Other
Member Identification_____
Soc Sec Number:_____
Employer Name:_____
Ins Co:_____
Ins Gp. Number:_____
Ins Phone Number:_____

Is there anything you would like to change about your smile? (Straighter teeth, Whiter smile, etc.)
_____
_____

Patient Registration

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have a important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes	○ No	If yes _____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If yes _____
Have you ever had a serious head or neck injury?	○ Yes	○ No	If yes _____
Are you taking any medications, pills, or drugs?	○ Yes	○ No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates?	○ Yes	○ No	If yes _____
Are you on a special diet?	○ Yes	○ No	If yes _____
Do you use tobacco?	○ Yes	○ No	If yes _____

For Women:

○ Pregnant/Trying to get pregnant ○ Nursing ○ Taking oral contraceptives

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Sulfa Drugs ○ Local Aesthetics

Other: _____

Do you use controlled substances? ○ Yes ○ No _____

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

Aids/HIV Positive	○ Yes	○ No	Excessive Thirst	○ Yes	○ No	Lung Disease	○ Yes	○ No
Alzheimer's disease	○ Yes	○ No	Fainting Spells/Dizziness	○ Yes	○ No	Mitral Valve Prolapsed	○ Yes	○ No
Anaphylaxis	○ Yes	○ No	Frequent Cough	○ Yes	○ No	Osteoporosis	○ Yes	○ No
Anemia	○ Yes	○ No	Frequent Diarrhea	○ Yes	○ No	Pain in Jaw Joints	○ Yes	○ No
Angina	○ Yes	○ No	Frequent Headaches	○ Yes	○ No	Parathyroid Disease	○ Yes	○ No
Arthritis/Gout	○ Yes	○ No	Genital Herpes	○ Yes	○ No	Psychiatric Care	○ Yes	○ No
Artificial Joint	○ Yes	○ No	Glaucoma	○ Yes	○ No	Radiation Treatments	○ Yes	○ No
Artificial Heart Valve	○ Yes	○ No	Hay Fever	○ Yes	○ No	Recent Weight Loss	○ Yes	○ No
Asthma	○ Yes	○ No	Heart Attack/Failure	○ Yes	○ No	Renal Dialysis	○ Yes	○ No
Blood Disease	○ Yes	○ No	Heart Murmur	○ Yes	○ No	Rheumatism	○ Yes	○ No
Blood Transfusion	○ Yes	○ No	Heart Pacemaker	○ Yes	○ No	Scarlet Fever	○ Yes	○ No
Breathing Problem	○ Yes	○ No	Heart Trouble/Disease	○ Yes	○ No	Sickle Cell Disease	○ Yes	○ No
Bruise Easily	○ Yes	○ No	Hemophilia	○ Yes	○ No	Sinus Trouble	○ Yes	○ No
Cancer	○ Yes	○ No	Hepatitis A	○ Yes	○ No	Spina Bifida	○ Yes	○ No
Chemotherapy	○ Yes	○ No	Hepatitis B or C	○ Yes	○ No	Stroke	○ Yes	○ No
Chest Pains	○ Yes	○ No	Herpes	○ Yes	○ No	Swelling of Limbs	○ Yes	○ No
Cold Sores/Fever Blisters	○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Congenital Heart Disorder	○ Yes	○ No	High Cholesterol	○ Yes	○ No	Tuberculosis	○ Yes	○ No
Convulsions	○ Yes	○ No	Hives or Rash	○ Yes	○ No	Tumors or Growths	○ Yes	○ No
Cortisone Medicine	○ Yes	○ No	Hypoglycemia	○ Yes	○ No	Ulcers	○ Yes	○ No
Diabetes	○ Yes	○ No	Irregular Heartbeat	○ Yes	○ No	Venereal Disease	○ Yes	○ No
Drug Addiction	○ Yes	○ No	Kidney Problems	○ Yes	○ No	Yellow Jaundice	○ Yes	○ No
Easily Winded	○ Yes	○ No	Leukemia	○ Yes	○ No			
Emphysema	○ Yes	○ No	Liver Disease	○ Yes	○ No			
Excessive Bleeding	○ Yes	○ No	Low Blood Pressure	○ Yes	○ No			

Have you ever had any serious illness listed? ○ Yes ○ No If yes _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X _____ _____

Patient Signature Date

X _____ _____

Doctor Signature Date