PATIENT REGISTRATION

(PLEASE PRINT)
Patient Full Name_____ Date_____

Mailing Address_____

Home Phone_____ Work Phone_____ Social Security Number _____

Sex ❑ M ❑ F Age_____ Date of Birth _____ ❑ Child ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Employed by_____ Occupation_____

Business Address_____

Spouse/Parent Full Name_____ Social Security Number_____

Mailing Address & Phone Number (if different) _____

Employed by_____ Occupation_____

Business Address_____ Work Phone_____

Who is responsible for this account?_____ Relationship_____

Dental Insurance Company_____

In case of emergency, who should be notified?_____ Phone_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Have you ever had any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Allergies to Anesthetics	☐	☐	Diabetes	☐	☐	Mitral Valve Prolapse	☐	☐	Sinus Problems
☐	☐	Artificial Joints/Heart Valve	☐	☐	Epilepsy	☐	☐	Nervous Problems	☐	☐	Stroke
☐	☐	Blood Disease/Hemophilia	☐	☐	Heart Problems	☐	☐	Psychiatric Care	☐	☐	Tuberculosis
☐	☐	Cancer	☐	☐	Hepatitis/Liver Disease	☐	☐	Radiation Treatment	☐	☐	Venereal Disease
☐	☐	Chemical Dependency	☐	☐	High Blood Pressure	☐	☐	Respiratory Disease	☐	☐	Other_____
☐	☐	Circulatory Problems	☐	☐	HIV/AIDS	☐	☐	Rheumatic Fever			_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ❑ Yes ❑ No
If yes, which one(s)?_____

Have you ever responded adversely to any medical or dental treatment?_____

What medications are you taking? _____

Are you under the care of a physician? ❑ Yes ❑ No For what conditions?_____

Physician's Name _____ Date of Last Physical _____

(Women) Do you know or suspect that you are pregnant? ❑ Yes ❑ No On birth control medication? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

Is there anything else we should know about your medical history?_____

_____

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. H. Ray Smith or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. It is my responsibility to inform Dr. Smith of any changes in my health status.

I hereby authorize Dr. Smith to make a thorough diagnosis of my dental needs, including x-rays if necessary, and to perform dental treatment using medication, anesthetics, and/or therapy as indicated.

I understand that the payment of my bill is my legal obligation. If I have insurance, I understand that my dental insurance carrier may pay less than the actual charges for services. I understand that I am responsible for any and all charges incurred for treatment received. Any assistance in filing insurance claims granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow-through, or confirmation. If this account is placed for collection, I agree to pay all legal fees, court costs, and other expenses incurred in the collection of this account. I further agree to pay returned check charges of $25 per returned check.

Signature of Patient or Responsible Party_____ Date_____