



**PATIENT REGISTRATION AND MEDICAL HISTORY**

(PLEASE PRINT)

Date \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_  
 Patient \_\_\_\_\_  
 Street Address \_\_\_\_\_ Last Name \_\_\_\_\_ City \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ State \_\_\_\_\_ Preferred Name \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Driver's License# \_\_\_\_\_  Single  Married  Divorced  
 Patient Employed by \_\_\_\_\_ Patient Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Spouse/Parent Name \_\_\_\_\_ Spouse/Parent Birthdate \_\_\_\_\_  
 Spouse/Parent Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Patient Social Security # \_\_\_\_\_ Spouse/Parent Social Security # \_\_\_\_\_  
 Dental Insurance Company 1) \_\_\_\_\_ 2) \_\_\_\_\_ Group #s \_\_\_\_\_  
 In Case of Emergency, Contact \_\_\_\_\_ Phone \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Have you ever had any of the following? (check all that apply)

- |                                                            |                                                               |                                                                        |
|------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Heart Problems                    | <input type="checkbox"/> Respiratory Disease                  | <input type="checkbox"/> Blood Disease                                 |
| <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Epilepsy                             | <input type="checkbox"/> Arthritis                                     |
| <input type="checkbox"/> Low Blood Pressure                | <input type="checkbox"/> Headaches                            | <input type="checkbox"/> Special Diet                                  |
| <input type="checkbox"/> Circulatory Problems              | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Swollen Neck Glands                           |
| <input type="checkbox"/> Nervous Problems                  | <input type="checkbox"/> Cancer                               | <input type="checkbox"/> Rheumatic Fever                               |
| <input type="checkbox"/> Radiation Treatment               | <input type="checkbox"/> Psychiatric Care                     | <input type="checkbox"/> Sinus Problems                                |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Chronic Diarrhea                     | <input type="checkbox"/> A.I.D.S. or Other Immunosuppressive Disorders |
| <input type="checkbox"/> Recent Weight Loss                | <input type="checkbox"/> Allergies to Anesthetics             | <input type="checkbox"/> Stroke                                        |
| <input type="checkbox"/> Back Problems                     | <input type="checkbox"/> Allergies to Medicines or Drugs      | <input type="checkbox"/> Ulcer                                         |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> General Allergies                    | <input type="checkbox"/> Venereal Disease                              |
| <input type="checkbox"/> Latex Allergy                     |                                                               | <input type="checkbox"/> Chemical Dependency                           |
| <input type="checkbox"/> Eye Surgery                       |                                                               | <input type="checkbox"/> Hemophilia                                    |

Do you have ANY drug allergies or have you ever had an adverse reaction to ANY medication? If so, what? \_\_\_\_\_

Have you ever responded adversely to medical or dental treatment? \_\_\_\_\_

Are you taking ANY medication at this time? \_\_\_\_\_ If so, what? \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No For what conditions? \_\_\_\_\_

If patient is a child, what is his/her weight? \_\_\_\_\_

(Women) Do you suspect that you are pregnant?  Yes  No Are you Nursing?  Yes  No

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

# DENTAL HISTORY

Previous Dentist (if applicable) \_\_\_\_\_ City \_\_\_\_\_

Date of last cleaning \_\_\_\_\_ Date of last dental visit \_\_\_\_\_ Why? \_\_\_\_\_

Have you had dental x-rays taken during the past three years?  Yes  No If so, what kind: \_\_\_\_\_

Bitewings (one or two on each side to detect cavities) Date \_\_\_\_\_

Complete Series (16 x-rays) Date \_\_\_\_\_

Panorex (sitting or standing and machine moves around head) Date \_\_\_\_\_

Is there any condition in your mouth that is causing you pain or discomfort?  Yes  No If yes, what kind: \_\_\_\_\_

Do you do any of the following? (check all that apply)

Bite cheeks or lips  Suck fingers  Breathe through mouth  Drink tea/coffee

Bite tongue  Bite fingernails  Tongue thrust  Chew tobacco

Clench teeth  Suck thumb  Notice bad breath frequently  Smoke (cig/pipe)

Are you satisfied with the appearance of your teeth?  Yes  No

What can we do for you today? \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Date \_\_\_\_\_ Signature \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with \_\_\_\_\_  
Name of Insurance Company(ies)

and assign directly to Hider Family Dentistry's Providers, all benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Insured/Guardian

## MINOR/CHILD CONSENT

I, being the parent or guardian of \_\_\_\_\_  
Name of minor/child do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Insured/Guardian

## FINANCIAL AGREEMENT

By signing below I acknowledge the following: (1) I am responsible for any and all payments or co-payments for services rendered; (2) Any claims submitted to insurance, which are subsequently declined shall become my responsibility; (3) In the event my owed balance should become delinquent, I acknowledge I may additionally become responsible for additional fees including but not limited to: late fees, collection fees, interest, court costs and attorney fees.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Insured/Guardian