# PATIENT REGISTRATION

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**Patient Information:**

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Sex: ○ Female ○ Male Birth date: _____

Social Security #: _____

E-mail: _____ □ I would like to receive email correspondences

Emergency Contact: _____ Phone # _____

**Responsible Party: ( if someone other than the patient )**

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

**Primary Insurance Information:**

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

**Employer:** _____ **Insurance Company:** _____

Address: _____ City, State, Zip: _____

**Secondary Insurance Information:**

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ City, State, Zip: _____

## DENTAL HISTORY

**Has the patient been to a dentist before? Yes No If yes when?** _____

**How often does patient brush?** _____ **Does the patient floss?** _____

**Is the patient having any trouble with teeth now? If so what?** _____

_____

## MEDICAL HISTORY

**Physician's Name** _____ **Date of last visit** _____

**Are there Medications taken daily? If so what are they:**

_____

**Are you allergic to any of the following?**

**Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics**

**Other If yes, please explain:**

**Do you take any medications on a daily basis?** _____

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

| | | | | |
|---|---|---|---|---|
| ____ A.I.D.S./H.I.V. | ____ Cerebral Palsy | ____ Epilepsy | ____ Kidney Disease | ____ Rheumatic Fever |
| ____ Anemia | ____ Chicken Pox | ____ Fainting | ____ Liver Disease | ____ Sinus Problems |
| ____ Asthma | ____ Convulsions | ____ Hearing Problems | ____ Measles | ____ Thyroid Disease |
| ____ Bladder Problems | ____ Diabetes | ____ Heart Problems | ____ Mononucleosis | ____ Tuberculosis |
| ____ Cancer | ____ Drug/Alcohol Abuse | ____ Hepatitis | ____ Mumps | ____ Other |

**Have you ever had any serious illness not listed above?** Yes No If yes, please explain: _____

_____

**Has the patient had any surgeries? Yes No** If yes what and when? _____

**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.**

**I certify that I, and/or my dependent(s), have insurance coverage with** _____ **and assign directly to Dr. Edward G. Stephens DDS all insurance 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 authorize the use of my signature on all insurance submissions.**

**The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.**

**SIGNATURE OF PATIENT, PARENT, or GUARDIAN** _____ **DATE** _____