PATIENT REGISTRATION & MEDICAL HISTORY

(Please Print)

Date______________________ Birth date__________________

Patient____

Street Address_________________________City___________State_______Zip______________

Home Phone#__________________________ Cell Phone#______________________________

Sex ☐M ☐F Age___________ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Employed by_____________________________Occupation____________________________

E-mail Address____

Work Address______________________________ Work Phone#__________________________

Spouse/Parent Name_________________________ Spouse/Parent Birth date__________________

Spouse/Parent Employed by___________________ Occupation___________________________

Business Address_______________________________ Business Phone#____________________

Who is responsible for this account? __________________ Relationship to Patient________________

Social Security#______-______-________ Spouse/Parent Social Security#______-______-________

Name of Dental Insurance Company________________________ ____Group #__________________

In case of emergency, who should be notified? ______________________ 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 boxes that apply):

☐Heart Problems
☐High Blood Pressure
☐Low Blood Pressure
☐Circulatory Problems
☐Nervous Problems
☐Radiation Treatment
☐Artificial Heart Valves or Joints
☐Recent Weight Loss
☐Back Problems
☐Diabetes
☐Respiratory Disease

☐Epilepsy
☐Headaches
☐Hepatitis, Jaundice, or Liver Disease
☐Cancer
☐Psychiatric Care
☐Chronic Diarrhea
☐Allergies to Anesthetics
☐Allergies to Medicine or Drugs
☐General Allergies
☐Blood Disease
☐Arthritis

☐Special Diet
☐Swollen Neck Glands
☐Rheumatic Fever
☐Sinus Problems
☐HIV, AIDS, or other Immunosuppressive Disorders
☐Stroke
☐Ulcer
☐Venereal Disease
☐Chemical Dependency
☐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? ☐Yes ☐No If so, what? ____________________________

Are you under the care of a physician? ☐Yes ☐No For what conditions? __________________________

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

(Woman) Do you suspect that you are pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No

Is there anything else we should know about you medical history? __________________________

Are you happy with your smile? ☐Yes ☐No

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 for benefits, 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 may have made in the completion of this form.

Date________________ Patient Signature______________________________

Comments:____

Dentist Signature____

Over⟶

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with ______________________________

Name of Insurance Company (ies)

And assign directly to Gillis & Dalton Family Dentistry PLLC 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 of my insurance submissions whether manual or electronic.

____

Date ***Signature***

MINOR/CHILD CONSENT

I, Being the parent or guardian of ______________________________ do hereby request and authorize

Name of minor/child

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

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

____

Date ***Signature of Insured/Guardian***

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐Yes ☐No

For what conditions?______________________________

Are you taking any new medications? ☐Yes ☐No If so, what? ______________________________

____

Date ***Patient Signature***

____

Date ***Dentist Signature***

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐Yes ☐No

For what conditions?______________________________

Are you taking any new medications? ☐Yes ☐No If so, what? ______________________________

____

Date ***Patient Signature***

____

Date ***Dentist Signature***