PATIENT REGISTRATION FORM

(PLEASE COMPLETE BOTH SIDES OF THIS FORM)

DATE:_____

How did you hear about our office?_____

Patient Name_____ Age_____ Birth Date_____/_____/_____

Contact Numbers: (_____)_____ (_____)_____ (_____)_____
Cell Phone # Home Phone # Alternative Phone #

Primary E-Mail _____ **2ND E-Mail** _____

Prefer Contact Method_____ **Texting?** YES NO

Home Address_____ City_____ State_____ Zip Code_____

Billing Address_____ City_____ State_____ Zip Code_____
(If different from home address)

Is patient currently a full time student? YES NO _____ _____
Name of School # of Units

Date of Last Dental Service_____/_____/_____ **Last Dental Service(s) Received:**_____

_____

What are your main dental concerns?

1. _____
2. _____
3. _____

PERSON OR PERSONS RESPONSIBLE FOR ACCOUNT

Name_____ **Spouse's Name** _____

Email_____ Email_____

Contact Phone #_____ Contact Phone #_____

Social Security #_____ Birth Date___/___/_____ Social Security #_____ Birth Date___/___/_____

Drive License # _____ State _____ Drive License #_____ State _____

Employed By _____ **Employed By**_____

Business Address _____ Business Address _____

_____ _____

Work Phone #_____ Ext._____ Work Phone #_____ Ext._____

Department _____ Department _____

Insurance Company _____ **Insurance Company**_____

Local #_____ Group #_____ Local #_____ Group #_____

Nearest relative (not living with you) in case of emergency_____

Address_____ City_____ State_____ Zip Code _____

Home Phone # (_____)_____ Cell Phone # (_____)_____ Other # (_____)_____

THE TREATMENT FEES ARE ONLY AN ESTIMATE

Fees are based on the usual, customary, and reasonable fees for the S.F. Bay Area.

You are personally responsible for payment of fees for services. Fee for service is due on scheduling or per prearranged payment plan. We accept Cash, checks, MasterCard, Visa, Discover Card, and American Express. We also have available a selection of payment plans upon credit approval. If you have dental insurance coverage, we will prepare any forms or reports necessary to assist you in collecting from your insurance company, but we cannot and do not guarantee an exact amount that your insurance company may pay. You may request a predetermination of benefit from your insurance company – please inform us of your request before scheduling for your treatment; however, this can delay your necessary treatment by as much as 8 to 10 weeks.

I as the patient, parent or legal guardian of a minor patient, by signing below, I agreed to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of the office.

Signature:_____ Consent is given to perform necessary dental treatment including minor Children.

YOU CAN NOW FIND US ON FACEBOOK!

CONFIDENTIAL HEALTH HISTORY

Date of Patient's Last Physical Exam:_____ Name of Physician:_____

Physician's Address:_____
Number & Street City State Zip

Physician's Phone #:_____ Fax #:_____ Kaiser Medical#_____

Are you taking any medication? *(Include vitamins, supplements, and herbal remedies)* ☐ YES ☐ NO
Please List: _____

_____

_____

Have you had any major surgery? ☐ YES ☐ NO
Please List:_____

_____

_____

Are you in good health? _____ ☐ YES ☐ NO
Are you allergic to any medication?_____ ☐ YES ☐ NO
If yes, please list:_____

_____

Are you taking daily aspirin? _____ ☐YES ☐NO

Are you taking blood thinning medication_____ ☐YES ☐NO

Are you taking *Fosomax*, or other *Osteoporosis/Osteopenia* (bone) medication? _____ ☐ YES ☐ NO
If yes, when did you start? _____ Name of Medicine_____

Have you ever taken *Fosomax, other bone medication* or *Fen-Fen* in the past? ☐ YES ☐ NO

If yes, for how many years?_____ When did you stop? _____
Name of the Medicine:_____

Have you had a negative reaction from any previous dental or medical care?_____ ☐ YES ☐ NO

Do you have history of *Heart Trouble, Rheumatic Fever, Epilepsy, TB, VD, Diabetes*, _____ ☐ YES ☐ NO
Hepatitis, Kidney, Blood, Asthma, Neurologic or Mental Disorders, HIV, AIDS,
Heart Murmur, (if yes, please circle), Other?_____

Do you have a hip or knee replacement? If yes, when? _____ ☐ YES ☐ NO

Do you have a Pacemaker?_____ ☐ YES ☐ NO

Do you have any prosthetic implants of any type?_____ ☐ YES ☐ NO

Do you ever experience a clicking or popping of your jaw? _____ ☐ YES ☐ NO

Do you get frequent headaches?_____ ☐ YES ☐ NO

Were you ever treated for or are you currently being treated for High Blood Pressure? _____ ☐ YES ☐ NO

Do you bleed easily? _____ ☐ YES ☐ NO

Are you currently under medical treatment? _____ ☐ YES ☐ NO

If yes, for what condition(s)? _____

Please list any additional medical information_____

Signature of Patient/Guardian: _____ **Date:** _____

Health History Reviewed/Updated: Date:_____ By Provider:_____ Pt's Initial: _____
Date:_____ By Provider:_____ Pt's Initial: _____
Date:_____ By Provider:_____ Pt's Initial: _____
Date:_____ By Provider:_____ Pt's Initial: _____