PATIENT REGISTRATION

(Please Print)

Date: _____

Patient: _____
Last Name First Name Middle Initial

Preferred Name_____ Preferred Pronoun _____

Address: _____ Apt/Unit No_____

City: _____ State: _____ Zip Code: _____

Cell Phone: (_____)_____ Alternative Phone: (_____)_____

Email address: _____

Date of Birth _____/_____/_____ Age: ___ Sex Assigned at birth:_____ Gender Identity:_____

Marital Status: □ Single □ Separated □ Married □ Widowed □ Divorced

Emergency Contact Name: _____ Phone Number: (___)_____

Whom may we thank for referring you? _____

Previous / Present Dentist: _____ Last Visit Date: _____

School / Employer_____

School / Employer Address_____

Dental Insurance Plan: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Address & Phone (if different from patient):_____

_____ Phone _____-_____-_____

Subscriber Phone: _____-_____-_____ Subscriber DOB: _____/_____/_____

Insurance ID Number: _____ Insurance Group Number_____

Medical Insurance Plan: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Address & Phone (if different from patient):_____

_____ Phone _____-_____-_____

Subscriber Phone: _____-_____-_____ Subscriber DOB: _____/_____/_____

Insurance ID Number: _____ Insurance Group Number_____

MINOR / CHILD CONSENT ONLY

I am the parent, guardian, or personal representative of _____

Please print name of minor/child

And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. I understand that it is my responsibility to inform my doctor if my minor / child ever has a change in health. Dr. Smith-Williams or Dr. Salim Afshar may use my minor / child's health care information and may disclose such information to the 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 Date

_____ _____

Please print name Relationship to Patient

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct.

INSURANCE ASSIGNMENT AND RELEASE

I assign directly to Dr. Jennifer E. Smith-Williams 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 doctors may use my health care information and may disclose such information to the company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor / child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

A $50 minimum charge will be made for failed or cancelled appointments without prior notification of two business days. Please remember, once an appointment is made this time has been reserved for you.

_____ _____

Signature Date

_____ _____

Please print name Relationship to Patient

Health History Form

Name: _____ Sex: M / F Date: _____

Date of Birth: _____ Weight: _____ Height: _____' _____"

For the following questions, please circle Yes or No, whichever applies.
Your answers are for our records only and will be considered confidential.

1. Yes No Are you in good health?
2. Yes No Has there been any change in your health in the past year?
3. My last physical exam was on _____/_____/_____
4. Yes No Are you now under the care of a physician?
   If so, for what condition?_____
5. The name and address of my physician
   _____

6. Yes No Have you had any serious illness, significant operation, or hospitalization within the past 5 years
   _____

7a. Yes No Are you taking any medications; prescribed?
Please list_____

7b. Yes No Are you taking any medications; over the counter or from a health food store?
Please list_____

8. **Do you have or have you had any of the following diseases or problems?**

Yes No Allergies
Yes No Angina
Yes No Do your ankles swell
Yes No Any other heart condition:_____
Yes No Arthritis
Yes No Asthma
Yes No Bronchitis or other respiratory problems
Yes No Chest pain upon exertion
Yes No Diabetes
Yes No Emphysema
Yes No Epilepsy
Yes No Fainting spells
Yes No Frequent or recurring mouth sores
Yes No Heart attack
Yes No Heart murmur, damaged heart valves, or artificial valves
Yes No Hepatitis, jaundice, or liver disease
Yes No High blood pressure
Yes No HIV
Yes No Hyperacidity or acid reflux
Yes No Kidney trouble
Yes No Low blood pressure
Yes No Persistent cough or cough that produces blood
Yes No Persistent swollen neck glands
Yes No Rheumatic Heart Disease
Yes No Seizures
Yes No Shortness of breath after mild exercise
Yes No Sinus trouble
Yes No Stomach ulcer
Yes No Stroke
Yes No Thyroid problems
Yes No TMJ
Yes No Tuberculosis
Yes No Are you taking aspirin?
Yes No Are you taking Coumadin, Plavix or any other blood thinners?

OVER

8. **Do you have or have you had any of the following diseases or problems? (cont)**
Yes No Any disease, drug or transplant operation that has depressed your immune system?
Yes No Are you taking any bone strengthening medicines e.g. Fosamax or any bisphosphonates?
9. Yes No Have you had abnormal bleeding?
10. Yes No Have you ever required a blood transfusion?
11. Yes No Do you have any blood disorder such as anemia?
12. Yes No Have you ever had treatment for a tumor or growth?
13. Yes No Do you currently, or did you in the last two years use recreational drugs?
14. Are you allergic to or have you had a reaction to any of the following:
Yes No Aspirin
Yes No Barbiturates or sleeping pills
Yes No Clindamycin
Yes No Codeine or other narcotics
Yes No Eggs
Yes No Erythromycin
Yes No Iodine
Yes No Latex or rubber products
Yes No Local anesthetics
Yes No Other antibiotics:_____
Yes No Penicillin
Yes No Percocet
Yes No Soy
Yes No Sulfa drugs
Yes No Vicodin
Yes No Other_____
15. Yes No Have you had any serious trouble associated with previous dental treatment?
If so, explain: _____
16. Yes No Do you have any other condition or disease you think the doctor should know about?
If so, explain: _____
17. Yes No Are you wearing contact lenses?
18. Yes No Are you wearing removable dental appliances?
19. Yes No Do you wish to talk with the doctor privately about anything?

Women

20. Yes No Are you pregnant or trying to become pregnant?
21. Yes No Do you have problems associated with your menstrual period?
22. Yes No Are you nursing?
23. Yes No Are you taking birth control?

What brings you to the doctor today:

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ **Patient's Signature:**_____

FOR COMPLETION BY THE DOCTOR

Comments on patient Interview: _____

_____

Date: _____ **Doctor's Signature:** _____

Health History Update:

Date:	Comments:	Signature:
_____	_____	_____