REGISTRATION FORM

Name _____ Today's Date _____
Address _____ Birth Date _____
City _____ Zip Code _____ S.S. No. _____ Sex _____
Telephone _____ Cell # _____ Marital Status: S M W D
Employer _____
Employer's Address _____
Employer's Telephone _____
Name of Spouse/Parent _____
Spouse's Soc. Sec. # _____ Birth Date _____
Spouse's Employment _____ Telephone _____
Dental Insurance Company _____ ID# _____
Referred by _____

HEALTH HISTORY

Circle Any Of The Following You Have Or Have Had At Present:

Heart Problems	Pacemaker	Epilepsy or Seizures
Mitral Valve Prolapse	High Blood Pressure	Hepatitis
Rheumatic Fever	Joint Replacement	Tuberculosis
Bacterial Endocarditis	(knee, hip)	HIV or AIDS
Heart Valve Replacement	Free Bleeder	Diabetes

	YES	**NO**
Are you in good health?	[]	[]
Do you have any allergies or unusual reactions to medicine?	[]	[]
If yes, explain_____		
Have you had any unexpected weight loss in the last year?	[]	[]
Do you have night sweats?	[]	[]
Are you under a Physician's care?	[]	[]
Please list all medications, including non-prescription_____	[]	[]
_____		
Are you pregnant?	[]	[]
Have you ever taken a bisphosphonate drug (a drug that builds bone structure)? For what and when_____	[]	[]
Other information about your health that we should know?	[]	[]

_____

Name of Physician _____

I authorize the dentist to release information including diagnosis, recommended treatment, and treatment rendered, to third party payers and practitioners.

I authorize and request my dental insurance company to pay direct to the dentist, insurance benefits otherwise payable to me.

I understand that my insurance company may pay less than the actual bill for services and that I am responsible for all costs of dental treatment.

Patient/Parent Signature _____ *Date* _____