Patient Registration

Name:____ Preferred Name:_______________
Last First MI

Title:_____________ Gender: M or F Family Status: Married, Single, Child
Mr, Mrs, Ms, Dr, etc

DOB:_______________ S.S.#: __________________ Email Address:______________________________

Phone: __________________ __________________ __________________ Best time to call:_____________
Home work mobile

Address: _____________________________________ City: ________________State:______Zip:___________

The following is for the: patient___ or the person responsible for payment____

Employer name: ____ Phone: _____________________________

Address: _____________________________________ City:________________State:______ Zip:___________

Spouse Name: ____ Phone: ______________________________

Spouse's Employer: _____________________________________ Phone: _____________________________

Name of Insured:____ DOB of Insured:____________________

ID #: ____________________________ Group: ____________________

Insured's Address: ____

Insured's Employer Name:____

Employer Address: ____

Relationship to patient: self_____, spouse_____, child______, other_______

Insurance Plan: ________________________ Address: ____

Physician's Name: ____Phone #:_________________________

How did you hear about our office? ____

What is most important about your smile, dental health and/or teeth?_______________________________

What would you like to accomplish with today's visit? ____

Health History

Indicate which of the following you have or have had by circling **Yes** or **No**.

Pre- Med Amox	Y	N	Pre-Med-Clind	Y	N	Pre-Med Other	Y	N
Allergies	Y	N	Allergy-Aspirin	Y	N	Allergy-Codeine	Y	N
Allergy-Erythro	Y	N	Allergy-Hay Fever	Y	N	Allergy-Latex	Y	N
Allergy-Other	Y	N	Allergy-Penicillin	Y	N	Allergy-Sulfa	Y	N
Anemia	Y	N	Arthritis	Y	N	Bisphosphonates	Y	N
Artificial Joints	Y	N	Asthma/Emphysema	Y	N	Cancer	Y	N
Blood Disease	Y	N	Blood Thinners	Y	N	Dizziness	Y	N
Chemotherapy Tx	Y	N	Diabetes	Y	N	Excessive Bleeding	Y	N
Drug Addiction	Y	N	Epilepsy/Seizures	Y	N	Head Injuries	Y	N
Fainting	Y	N	Glaucoma	Y	N	Heart/Valve Surgery	Y	N
Heart Disease	Y	N	Heart Murmur	Y	N	HIV	Y	N
Hepatitis	Y	N	High Blood Pressure	Y	N	Liver Disease	Y	N
Jaundice	Y	N	Kidney Disease	Y	N	Nervous Disorders	Y	N
Lupus	Y	N	Mental Disorders	Y	N	Radiation Treatment	Y	N
Other	Y	N	Pacemaker	Y	N	Rheumatism	Y	N
Respiratory Problems	Y	N	Rheumatic Fever	Y	N	Stroke	Y	N
Sinus Problems	Y	N	Stomach Problems	Y	N	Tobacco Products	Y	N
Thyroid	Y	N	TMJ	Y	N	Ulcers	Y	N
Tuberculosis	Y	N	Tumors	Y	N			

Are you pregnant? Y N If yes, what month? _____________ Are you nursing? Y N

List **ALL** medications and herbal supplements: ____

____

Do you have any heart conditions or joint replacements that require premedication?______________________

Any other conditions we should be aware of? ____

Previous Dentist: ____

How long since your last dental visit? ____

We understand that a situation may arise that could force you to postpone your treatment. Please understand that such changes affect not only your dentist but our ability to help other patients. Dr Márquez's time, as well as that of our staff, is a precious commodity and we request your courtesy and respect. A $50 administrative fee will be charged to patients who habitually change or cancel their appointments within 48 hours of their scheduled visit.
I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I further understand that a collection fees may be added to overdue balances.
I authorize release of any information for insurance, medical or dental purposes.
I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

Signature:____Date:_____________
Patient/Guardian

Signature:____Date:_____________
Doctor