DosSantos Dental

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PERSONAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU, START HERE

Date	Last Name	First Name		
Spouse Full Name				
Address				
City		State	Zip Code	
Home Phone Number	Cell Phone Number			
Birthdate	Age	Male	Female	
Married	Single	Divorced	Widowed	Other
Social Security Number	Email Address			

IF THIS APPOINTMENT IS FOR YOUR CHILD, START HERE

Date	Last Name	First Name	
Address			
City		State	Zip Code
Home Phone Number	Social Security Number		
Birthdate	Age	Male	Female
School		Grade	
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO			

DENTAL INSURANCE

PRIMARY CARRIER		
Insurance Company	Group Number	
Employee		
Date of Birth	Date Employed	Union or Local Number
Employee Number	Employee Social Security Number	
SECONDARY CARRIER		
Insurance Company	Group Number	
Employee		
Date of Birth	Date Employed	Union or Local Number
Employee Number	Employee Social Security Number	

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ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT		
Name		
Birthdate	Social Security Number	
Address		
City	State	Zip Code
Phone Number	Email Address	
SPOUSE		
Name		
Birthdate	Social Security Number	
Occupation		
EMPLOYER		
Company/Organization/Business Name		
Business Address		
Business Phone Number	Extension	

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
Name	Relationship	
REFERRED TO US BY		
Name		
EMERGENCY PERSON TO CONTACT		
Name		
Address		
City	State	Zip Code
Phone Number	Email Address	
CLOSEST RELATIVE NOT LIVING WITH YOU		
Name		
Address		
City	State	Zip Code
Phone Number	Email Address	

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MEDICAL HISTORY

	YES	NO
1. Are you having pain or discomfort at this time?		
2. Have you been a patient in the hospital during the past two years?		
3. Have you been under the care of a medical doctor during the past two years?		

Physician's Name	Phone Number		
Address	City	State	Zip Code

	YES	NO
4. Have you taken any medication or drugs during the past two years?		
5. Are you now taking any medication, drugs or pills?		

If yes, please list:

	YES	NO
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?		

If yes, please list:

7. Indicate which of the following you have had or have at present. Check "yes" or "no" for each item.

	YES	NO		YES	NO
Heart Failure			Artificial Joints (hip, knee, etc.)		
Heart Disease or Attack			Kidney Trouble		
Angina Pectoris			Ulcers		
Congenital Heart Disease			Diabetes		
Heart Murmur			Thyroid Problems		
High Blood Pressure			Glaucoma		
Arteriosclerosis			Cosmetic Surgery		
Mitral Valve Prolapse.			Emphysema		
Artificial Heart Valve			Chronic Cough		
Heart Pacemaker			Tuberculosis		
Heart Surgery			Asthma		
Rheumatic Fever			Hay Fever		
Arthritis			Allergies or Hives		
Rheumatism			Sinus Trouble		
Cortisone Medicine			Radiation Therapy		
Drug Addiction			Chemotherapy		

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	YES	NO		YES	NO
Stroke			Hepatitis A (infectious)		
Hepatitis B (serum)			Bruise Easily		
Venereal Disease			Liver Disease		
A.I.D.S.			Yellow Jaundice		
H.I.V. Positive			Epilepsy or Seizures		
Cold Sores/Fever Blisters			Fainting or Dizzy Spells		
Blood Transfusion			Nervousness		
Hemophilia			Psychiatric Treatment		
Anemia			Developmentally Disabled		
Sickle Cell Disease					

	YES	NO
8. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?		
9. Do your ankles swell during the day?		
10. Do you use more than two pillows to sleep?		
11. Have you lost or gained more than 10 pounds in the past year?		
12. Do you ever wake up from sleep and feel short of breath?		
13. Are you on a special diet?		
14. Has your medical doctor ever said you have a cancer or tumor?		
15. Do you have, or have you had, any disease, condition, or problem not listed?		

If yes, please list:

FOR WOMEN ONLY

	YES	NO		YES	NO
Are you pregnant?			Are you nursing?		
If yes, what month?			Are you taking birth control pills?		

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature

Date

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CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of Patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment for 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. In the event payments are not received by the agreed upon dates, I understand that 1-1/2% finance charge (18% APR) may be added to my account.

Patient	Date
Witness	Date
Parent or Responsible Party	Date
Relationship to Patient	

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