

# Patient Registration

(If you have dental insurance, please complete the reverse side)

Patient Name:			Social Security #:		
Last Name	First Name	Initial			
Address:		City:	State:	Zip Code:	
Home #:( )	Work #:( )	Cell #:( )	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	
E-mail:		Employer/School:			
Who is responsible for this account?		Relationship to Patient:			
Address:		City:	State:	Zip Code:	
Phone:( )		Social Security #:			
Emergency Contact:		Phone:( )	Relationship:		
Whom may we thank for referring you?					

## Dental Information

Reason for today's visit:		
Date of last dental care:	What was done at that time?	Date of last x-rays:

## Medical History

<b>Are you allergic to or have you had a reaction to:</b>	Yes	No	<b>Have you had an orthopedic total joint replacement?</b> <input type="checkbox"/> Y <input type="checkbox"/> N
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	When was the operation done?: _____
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Any complications?: _____
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Has a physician recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> Y <input type="checkbox"/> N
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	What was the antibiotic and the dose? _____
Latex	<input type="checkbox"/>	<input type="checkbox"/>	
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	
Metals (specify):	<input type="checkbox"/>	<input type="checkbox"/>	
Specify reaction for YES responses: _____			
			<b>Women Only</b>
			Are you or could you be pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N
			Nursing? <input type="checkbox"/> Y <input type="checkbox"/> N
			Taking Birth Control? <input type="checkbox"/> Y <input type="checkbox"/> N

Please indicate if you have or have had any of the following conditions:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding                      | <input type="checkbox"/> Fainting                      | <input type="checkbox"/> Hemophilia                       |
| <input type="checkbox"/> AIDS or HIV infection                  | <input type="checkbox"/> Heart Disease (specify below) | <input type="checkbox"/> Hepatitis/Jaundice/Liver disease |
| <input type="checkbox"/> Rheumatoid arthritis                   | <input type="checkbox"/> Artificial Heart Valves       | <input type="checkbox"/> Kidney Problems                  |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Congenital Heart Defect       | <input type="checkbox"/> Osteoporosis                     |
| <input type="checkbox"/> Cancer/Chemotherapy/ Radiation Therapy | <input type="checkbox"/> Heart Attack                  | <input type="checkbox"/> Sexually Transmitted Disease     |
| <input type="checkbox"/> Chemical Dependency                    | <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Tobacco Use                      |
| <input type="checkbox"/> Diabetes, type: _____                  | <input type="checkbox"/> Low Blood Pressure            | <input type="checkbox"/> Tuberculosis                     |
| <input type="checkbox"/> Epilepsy                               | <input type="checkbox"/> Pacemaker                     |   |

Is there anything else we should know about in your medical history?

Are you under a Physician's care? Y N For what Conditions: \_\_\_\_\_

Please list any medications you are taking at this time: \_\_\_\_\_

I certify that I have read and understand the above. I acknowledge that the above information is accurate and complete and is only for the use in my treatment, billing, and processing of insurance. I will not hold my dentist or any other member of his/her staff responsible for any errors or omission that I may have made in the completion of this form.

X \_\_\_\_\_ Date \_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

## OFFICE USE ONLY

Medical History Updated: X _____ Date _____	X _____ Date _____
X _____ Date _____	X _____ Date _____

## Dental Insurance Information

Please provide us with the following information:

Policyholder Name:	Relationship to Patient:
Policyholder Social Security# or Insurance ID#:	Policyholder Date of Birth:
Insurance Company Name and Address:	Employer or Group Name:
	Group Number:
Insurance Company Phone #:	

## Signature on File

As a courtesy to our patients, we file your dental insurance. Please sign this form so that we may submit claims on your behalf.

- I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance not covered by my insurance benefits.
- I authorize the release of information required to process my dental claim.

X

Patient/Parent or Guardian Signature

Date

- I authorize and direct dental payments from my insurance company to be paid directly to Jack P. Horbal, DDS

X

Subscriber Signature

Date