REGISTRATION

Date: _____

Patient's Name: _____ How do you prefer to be addressed? _____

Sex: Male Female Age: _____ Birth Date: _____ SSN: _____

Single Married Divorced Widowed E-mail Address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Work Ph: : _____

Occupation: _____ Employer: _____

Responsible Party on Account (if different from above): _____

Relationship to Patient: _____ Phone: _____ Home Cell Work (circle one)

Responsible Party Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Ph: _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE

PRIMARY – Policy Holder's Name: _____ Employer: _____

Birth Date: _____ SSN: _____ Relationship to Patient: _____

Ins. Provider: _____ Member/Subscriber ID: _____ Group #: _____

SECONDARY – Policy Holder's Name: _____ Employer: _____

Birth Date: _____ SSN: _____ Relationship to Patient: _____

Ins. Provider: _____ Member/Subscriber ID: _____ Group #: _____

HEALTH HISTORY

Physician's Name: _____ Date of Last Physical: _____

Do you have (or have you had) any of the following? Please mark all that apply:

❑ Any Heart Problems	❑ Cancer/Tumors	❑ Arthritis	❑ Seizure/Epilepsy
❑ High/Low Blood Pressure	❑ Radiation/Chemo	❑ Asthma	❑ Kidney Problems
❑ Rheumatic Fever	❑ Excessive Bleeding	❑ Lung Problems	❑ Liver Problems
❑ Scarlet Fever	❑ Stroke	❑ Psychiatric Care	❑ Epstein-Barr
❑ Hepatitis A, B, C	❑ Herpes Virus	❑ Ulcer(s)	❑ Multiple Sclerosis
❑ Tuberculosis	❑ Anemia	❑ Blood Transfusion	❑ AIDS or HIV
❑ Persistent Cough	❑ Thyroid Problems	❑ Sinus Problems	❑ Diabetes
❑ Pacemaker	❑ Heart Murmur	❑ Blood Thinner	❑ Currently Pregnant

Do you have any artificial joints/prosthesis? **Y N** Please List: _____

Have you ever taken any osteoporosis or biophosphonate medications? **Y N** Please List: _____

Do you require antibiotics before dental treatment? **Y N** Preferred antibiotic? _____

Do you smoke, chew, use snuff or any other forms of tobacco? _____ If so, how much? _____

Please List All Medications: _____

_____

Are you allergic to or have you reacted adversely to any of the following? (circle all that apply)

Local Anesthetic Penicillin Codeine Pain Relievers Epinephrine Tetracycline Sedatives Latex

Do you have any other allergies? _____

Would you like whiter teeth? **Y N** Would you like to find out about cosmetic options for your smile? **Y N**

Purpose of Today's Visit? _____

Please read the following agreement carefully and sign below:

I certify that the above questions have been accurately answered. I agree to pay for all services rendered by Meadows & Avery, DDS. I understand that Meadows & Avery, DDS will file any applicable insurance claims and make every effort to provide me with correct information about my insurance benefits; however, I recognize that I am ultimately responsible for understanding my insurance benefits and **if, for any reason, my insurance company does not remit the estimated amount, I agree to pay the balance on my account**. I understand that this office is HIPAA compliant and a copy of the privacy policy will be provided upon request.

X_____

Patient Signature (Parent/Guardian Signature if Patient is Under 18)