Medical History Date:______________

Do you now have or have you ever had any of the following:

	Yes	No	Don't know
Bleeding disorders, anemia................................	___	___	___
Diabetes..	___	___	___
Liver disease, hepatitis..	___	___	___
Prosthetic heart valve, cardiac transplantation......	___	___	___
Congenital heart disease, endocarditis................	___	___	___
Heart Disease, Pacemaker.................................	___	___	___
High blood pressure..	___	___	___
Prosthetic replacement of any joint......................	___	___	___
Arthritis..	___	___	___
Lupus...	___	___	___
Immunosuppression..	___	___	___
Radiation treatment...	___	___	___
Chemotherapy..	___	___	___
Sinus disease...	___	___	___
Allergy to any medicines.....................................	___	___	___
Allergy to any antibiotics.....................................	___	___	___
Osteoporosis treated with medication	___	___	___
Medical condition requiring hospitalization...........	___	___	___
Medical condition treated by your physician.........	___	___	___
Do you use any form of tobacco?	___	___	___
Have you ever used any form of tobacco?	___	___	___

Please answer these questions. Use the space below if you need more.
Please list any medicines you are taking._____________________________________
Have you ever taken a bisphosphonate medication such as: Boniva, Fosamax, Zometa, Didronel, Skelid, Actonel, Aredia? If yes please circle the medicine.
Have you ever been hospitalized? If so, for what?_____________________________
Are you receiving treatment from your physician? If so, for what?_______________
Who is your physician? Where is the office?_________________________________
What is the reason for your visit?____

Signature:_____________________________________Date:______________________

Please complete both sides.

Adult Registration

Today's Date:___________________

Name:____

Birthdate:_____________Age:___________Male:______Female:______

Spouse's Name:_____________________________________

eMail Address:___________________________________

Mailing Address:___________________________________

City:_________________State:________Zip:________

Phone-home:_____________Phone-work:_____________Phone-Cell:_____________

How would you prefer to be contacted for appointment confirmation?

___Phone ___Text ___Email

Who will pay this account ?______________________________

In case of emergency provide the name and phone number of someone not at your home whom we might contact.____

Insurance Information

Please provide name and date of birth of insured person if it differs from information above:____

Name and address of dental insurance company:

____

____

Policy#: ____

Employer/Plan Sponsor: ____________________________

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

›____ ____________________

Signed (Patient* – see reverse) Date

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

›____ ____________________

Signed (Employee/subscriber) Date

Insurance companies require that we obtain the above signatures to process your claims even though we submit almost all claims electronically. Signing above allows us to send paperless information to the insurance company about your visit. If this is your first visit this might include: an initial exam (D0140), x-rays (D0210, D0330 or D0274).

You avoid the inconvenience of waiting for the insurance company to reimburse you for services by allowing the insurance company to pay directly to us.