Patient Registration and Medical History
(Please Print)

Employee Initials: __________

Date ___________

Patient Name ______________________________ _____ _________________________________
Last First M.I. Preferred Name
Street Address ______________________________City __________________State _____ Zip ________
Home Phone ( ) ___________ Cell Phone ( ) ___________ Email ___________________________
Sex: M or F Age _____ Birth date ___________ Status : S M W D
Employer ___________________________________Occupation _________________________________
Business Address _________________________Business Phone __________________________________
Spouse/Parent Name _______________________________ Spouse/Parent Birth Date _________________
Spouse/Parent Employed by ____________________________ Occupation __________________________
Business Address ____Business Phone ___________________
Responsible party for this account ____________________ Relationship to the Patient _______________
SSN # _________________ Spouse/Parent SSN# _____________ Dental Ins. Co ____________________
Group # for Dental Ins. _________________ Emergency Contact Name ____________________________
Emergency Contact Number _________________ Who referred you to us? __________________________

Medical History

Physician's Name & Number _______________________ Date of last Physical ____________________

Have you had any of the following? (Circle all that apply)

Heart Problems	Epilepsy	Special Diet
Heart Murmur	Tobacco Use	Swollen Neck Glands
High / Low Blood Pressure	Hepatitis A / B / C	Rheumatic Fever
Cancer	Jaundice, Liver Disease	Sinus Problems
Radiation Treatment	Psychiatric Care	HIV/AIDS
Circulatory Problems	Mitral Valve Prolapse	Thyroid Disease
Artificial Heart Valve or Joint	Allergies to Anesthetics	Stroke
Recent Weight Loss	Allergies to Medicine or Drugs	Ulcer
Back Problems	General Allergies	Venereal Disease
Diabetes	Blood Disease	Chemical Dependency
Respiratory Disease	Arthritis	Hemophilia

Do you have any drug allergies, or have you ever had an adverse reaction to any medication? _________
If yes then what?____
Have you ever responded adversely to Medical or Dental treatment?______________________________
Are you taking any Medications at this time? ________
If yes then what?____
Are you under a Physician's care? _________ For what Conditions? ______________________________
If the patient is a child what is his or her weight? ________________________________
(Women Only) Are you pregnant? ___________ Are you nursing? _________________
Is there anything else about your Medical History we should know? __________________
____
The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled to. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Date _______________ Signature _______________________________________

Assignment and Release

I, the undersigned, have insurance with ____
and assign directly to Dr. __________________________all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby release any and all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date ___/___/___ Signature _____________________________________

Consent

I, ______________________________ do hereby authorize Grand Family Dentistry to perform necessary dental services on myself, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor.

Date ___/___/___ Signature _____________________________________

Minor/Child Consent

I, being the parent or legal guardian of ________________________________ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the Dr. whether or not I am present for the treatment being rendered.

Date ___/___/___ Signature _____________________________________

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents/guardians are responsible for any and all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance, and agree to pay any fees associated with delinquent payments, collection costs, and attorney fees or court costs associated with collections.

Date ___/___/___ Signature _____________________________________

HIPAA

I do hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that I may ask any questions I may have regarding this notice.

Date ___/___/___ Signature ____________________________

Release Information

I the undersigned, give authorization to release information about my records and condition (including diagnosis, treatment, and account transactions) to the following individual(s). If the patient is a minor, the undersigned gives authorization for the release of information about the minor's records and condition (including diagnosis, treatment, and account transactions) to the following individual(s).

________________________________ ________________________________

Printed Name and relationship to patient Printed Name and relationship to patient

________________________________ ________________________________

Signature of Parent/Guardian Today's Date