

Welcome to Professional Dental

Please complete this form and e-mail it to: profdds@aol.com

Please Print and sign this form and bring it with you to your first appointment.

Patient Registration

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Name of responsible party: _____

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

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

Home Phone: _____ WorkPhone: _____ Ext _____

Cell Phone: _____ E-Mail: _____

DL# _____ Birth Date: ____/____/____ Social Security: _____

Sex (circle one) Male or Female Marital Status (circle one): Married Single Divorced Widowed Separated

Employment Status: ____ FT ____ PT ____ Retired Student status: ____ FT ____ PT

Name of Employer: _____

Pharmacy Name and # _____

Primary Physician Name _____ Phone# _____

Primary Insurance Information

Name of Insured: _____ Relationship to patient: ____ Self ____ Spouse ____ Child/Other

Social Security: _____ Date of Birth: ____/____/____ Employer: _____

Carrier Name: _____ ID# _____ Group # _____

Carrier's Phone # _____

Carrier's Address _____

Medical Carrier's Name: _____ Phone#: _____

Medical ID#: _____ Group#: _____

Medical Carrier's Address: _____

Secondary Insurance Information

First Name: _____ Last Name: _____ Middle Initial: _____

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

Title Preferred(circle one): Mr. Mrs. Ms. Miss Dr.

Home Phone: _____ Work Phone: _____ Cell: _____

Social Security: _____ Birth Date: ____/____/____ DL# _____

Carrier Name: _____ ID# _____ Group# _____

Carrier's Address: _____

Relationship to Patient: ____ Self ____ Spouse ____ Child/Other

Dental/Health History

Patient's First Name: _____ Last Name: _____ Middle Initial: _____
As required by law, our office adheres to written policies and procedures to protect the privacy of information. Your answers are for our records only and will be kept confidential subject to applicable laws.

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Latex Novocaine Sulfa Food _____
 Other _____

Please check if you **have** or **ever had**:

- Heart Disease – please specify _____
- Heart Attack – date: _____
- Rheumatic Fever
- Cancer - if yes type: _____ Have you or are you being treated with radiation? _____
- Hepatitis A Hepatitis B – date: _____ Hepatitis C
- Stroke
- Aids/HIV
- Artificial Replacement of any kind – please specify type: _____ date: _____
- Tuberculosis date: _____
- Diabetes
- Mitral Valve Prolapse
- Excessive Bleeding Blood Thinner (such as aspirin or cumaden), milligrams _____
- Emphysema COPD Asthma
- Cold Sores Jaw or Neck Pain
- High Blood Pressure List medications: _____

Are you or have you ever taken any osteoporosis medications? _____
Have you had any recent surgeries? _____
Do your gums bleed? _____ Do you smoke? _____
Are you or could you be pregnant? _____
Are you currently taking any antibiotic? _____ How long? _____
Pharmacy Name and # _____
Primary Physician Name _____ Phone# _____

Do you like your smile? _____ If not what don't you like? _____

HIPAA POLICY: Please answer. May we speak to a member of your family regarding your health? ___yes ___no
If yes, with whom may we specifically speak? _____ Relationship _____

Consent to treat: You have my consent and authorization to keep a record of my signature to submit claims on my behalf as required by my insurance company. I hereby consent that any dentist or staff may take diagnostic x-rays, photos, and/or models deemed necessary by the dentist to properly and effectively diagnose and determine treatment. **I understand that I will be responsible for any expense that may incur regardless of insurance.** You may choose to refuse consent; we have the right to refuse treatment. Treatment is determined by the doctor and the patient and what we mutually agree to be the best treatment plan, therefore your insurance carrier's determination of what treatment they'll cover has no bearing on what treatment is best for the patient. **We strive to deliver the best care which, unfortunately, your insurance carrier doesn't always consider and may not pay.**

Signature: _____ **Print:** _____ **Date:** _____