Confidential

Patient Registration Form

ALLEGIANCE DENTAL

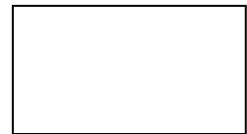

Chart #

Patient's Name ______________________________ Date of Birth ____________ □ Male □ Female
Last First Initial

If Child: Parent's Name ______________________________

Street Address ______________________City __________ State ______ Zip ______

Home Phone ______________ Work Phone ________________ Cell Phone __________

Fax ______________ E-Mail ______________________________

Social Security Number ________________

Employer ________________ Address ______________________

Who is Responsible for this account ______________Driver's License No. __________

Name of nearest relative not living with you ________________ Relationship __________

Telephone ______________ Address ______________________________

How did you hear about us:__________ Whom may we thank for this referral ______________

REFERRAL

How did you hear about us:__________ Whom may we thank for this referral ______________

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insurance Company ________________________ Group/Policy # __________

Name of Subscriber ________________________ Member ID/Social Security # __________

Date of Birth __________ Employer ______________________________

Street address ______________________________

City ______________________ State __________ Zip ______________

DUAL INSURANCE COVERAGE:

Name of Insurance Company ________________________ Group/Policy # __________

Name of Subscriber ________________________ Member Id/Social Security # __________

Date of Birth __________ Employer ______________________________

PATIENT SIGNATURE ______________________________ DATE: __________

Confidential

MEDICAL HISTORY

ALLEGIANCE DENTAL

Physician's Name____________________________ Date of Last Physical: _________________________________

Have you ever had any of the following? (Check if applicable)

__ Heart Problems
__ High Blood Pressure
__ Low Blood Pressure
__ Circulatory Problems
__ Nervous Problems
__ Radiation Treatment
__ Artificial Heart Valves or Joints
__ Recent Weight Loss
__ Diabetes
__ Back Problems
__ Allergies to Latex

__ Epilepsy
__ Headaches/Migraines
__ Hepatitis/Jaundice or Liver Disease
__ Cancer
__ Psychiatric Care
__ Chronic Diarrhea
__ Allergies to Anesthetics
__ Allergies to Medicine or Drugs
__ General Allergies
__ Blood Disease
__ Phen–Phen
__ Arthritis

__ Special Diet
__ Swollen Neckglands
__ Rheumatic Fever
__ Sinus Problems
__ "A.I.D.S."
__ Immunosuppressive Disorder
__ Stroke
__ Ulcer
__ Venereal Disease
__ Chemical Dependency
__ Hemophilia

Do you have any drug allergies or have ever had an adverse reaction to any medication? ______ Yes ______ No
If so, what?___________________________

Do you require pre-medication before dental treatment? ______ Yes ______ No

Have you ever responded adversely to medical or dental treatment? ____

Are you taking any medication at this time? ______ Yes ______ No
If so, what? ____

Please notify your dentist if you have taken or are currently taking any of the medications listed below:
(Check if applicable)

__ Actonel (Risedronate)
__ Aredia (Pamidronate)
__ Bonival (Ibandronate)
__ Didronel (Etidronate)

__ Fosamax (Alendronate)
__ Skelida (Tiludronate)
__ Zometa (Zoledronic Acid)

__ Blood Thinners

Are you under the care of a physician? ______ Yes ______ No If so, for what? ______________________________

(Women) Do you suspect that you are pregnant? ______ Yes ______ No Are you nursing? ______ Yes ______ No

Tobacco use: Never ______ Quit on (date) _________ Current Smoker: packs/day ______ years used ______

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

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 benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may made in the completion of this form.

PATIENT SIGNATURE ____ DATE: _______________