Dental Associates, Inc.

Dr. Bob Carney Dr. Phil Fisher Dr. Trey Carney

Registration & History Form

Date _____

Birthdate _____

Patient Information **(CONFIDENTIAL)** SS # _____

Name _____ Preferred Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Position _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Person to Contact in Case of Emergency _____ Phone _____

Whom May We Thank for Referring You? _____

Which Doctor Will You Be Seeing? _____

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birthdate _____ SS # _____ Work Phone _____

Are You in Bankruptcy or Contemplating Bankruptcy? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Patient Dental History

	Yes	No
1. Are you interested in improving your smile?	☐	☐
2. Are you interested in whitening your teeth?	☐	☐
3. Are you interested in replacing any missing teeth?	☐	☐
4. Do you have any old fillings or dental treatments that you are unhappy with?	☐	☐
5. Do your gums bleed while brushing or flossing?	☐	☐
6. Are you having any trouble with your teeth or gums?	☐	☐
7. Have you ever had any difficult extractions in the past?	☐	☐
8. Have you ever had any prolonged bleeding or problems healing following an extraction / dental treatment?	☐	☐

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
blood thinner or aspirin?	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use alcohol?	☐	☐
6. Are you allergic to any medications?	☐	☐
Local anesthetics? (e.g. novocaine)	☐	☐
Penicillin or other antibiotics?	☐	☐
7. Have you ever been treated for osteoporosis?	☐	☐
8. Are you pregnant or think you may be pregnant?	☐	☐

Please list any medications that you are taking

_____

_____

_____

please list _____

Do you have or have you had any of the following?

	Yes	No
High Blood Pressure	☐	☐
Rheumatic Fever	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
AIDS or HIV infection	☐	☐
Thyroid Problem	☐	☐
Heart Problem	☐	☐
What kind? _____		
Heart Murmur	☐	☐
Angina	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitus/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stroke	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Liver Disease	☐	☐
Respiratory Problems	☐	☐
Taking blood thinners	☐	☐
Other	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practicioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____

Signature of patient or parent if minor

Medical History Updates	