(Please Print)

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____Home Phone _____Cell Phone _____E-mail address_____

Patient _____
Last Name First Name Preferred Name

Street Address _____City_____State_____Zip Code_____

Sex: ☐ Male ☐ Female Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____Occupation_____

Business Address _____Business Phone_____

Spouse/Parent Name _____Spouse/Parent Name Birthdate_____

Spouse/Parent Employed by_____Occupation_____

Business Address _____Business Phone_____

Who is responsible for this account? _____Relationship to Patient _____

Social Security # _____Spouse/Parent Social Security # _____

Name of Dental Insurance Company _____Group Number _____

In case of emergency, who should be notified? _____ Phone # _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____Date of Last Physical _____

Have you ever had any of the following? (Check all boxes that apply)

- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Sleep Apnea / Snoring
- ☐ Radiation Treatments
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice, or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Mitral Valve Prolapse
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicines or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ AIDS / HIV
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____

If so, what? _____

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

Are you taking any medication at this time? _____ If so, what? _____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? _____

If the patient is a child, what is his / her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you Nursing? ☐ Yes ☐ No

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

Date_____ Signature _____

(NEXT PAGE)

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)
and assign directly to Dr. Merlo and Dr. Hirschenberger 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 my insurance. I hereby authorize the doctors to release 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*

MINOR / CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of minor / child
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 deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date *Signature of Insured / Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents / guardians are responsible for all fees and services rendered for treatment of a minor / child. I accept full financial responsibility for all charges not covered by my insurance.

_____ _____
Date *Signature of Insured / Guardian*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? ☐ Yes ☐ No If so, what? _____

_____

_____ _____ _____
Date *Patient Signature* *Doctor Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? ☐ Yes ☐ No If so, what? _____

_____

_____ _____ _____
Date *Patient Signature* *Doctor Signature*