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Patient Registration Form

Date _____

Name _____ Mr. Mrs. Ms. Miss Dr. Rev.

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ Marital Status: S M D W Home Phone (____) _____

SSN _____ - _____ - _____ Sex: M F Work Phone (____) _____

Email _____ Cell Phone (____) _____

Spouse Name _____ Spouse Date of Birth ____/____/____

Employer Name, Address _____ Occupation _____

Person responsible for this account _____ Relationship _____

Emergency Contact _____ Phone (____) _____

Whom may we thank for referring you to our office? _____

Dental Insurance Information

Name of Insured Person _____ Relationship _____ Date of Birth ____/____/____

ID# or SSN _____ BC/BS# _____ FEP R# _____

Employer Name, Address _____

Dental Insurance Co. _____ Address _____

Insurance Co. Phone (____) _____ Policy # and/or Group # _____

Secondary Dental Coverage? No Yes: Please provide information on your coverage. We will be happy to file your secondary claim for you. You are responsible for all co-payments before your secondary insurance is filed. Your secondary insurance will be instructed to reimburse you directly.

Secondary Ins Co. Name, address and phone _____

I understand that I am responsible for the cost of this care regardless of insurance coverage and deductibles. I authorize release of information as it relates to my dental treatment and my insurance coverage.

Signature _____ Date _____

Please complete the other side of this form with your Dental and Medical History.

Dental History

Reason for today's visit? _____

At the present time, do you have any dental complaints or concerns? _____

When was your last dental visit? _____ Previous dentist's name _____

Previous dentist's address _____ Phone (_____) _____

Medical History

Are you presently under the care of a physician? Yes No Physician's name _____

Physician's address _____ Phone (_____) _____

Has there been any change in your general health in the last year? No Yes, please explain _____

Date of last physical examination _____ Please list any medications, including non-prescription, which you are currently taking: _____

Have you had any serious illnesses, operations or been hospitalized in the last 3 years? No Yes, please explain _____

Conditions (please mark all that apply):

- | | | | |
|---|---|--|----------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Rheumatic fever | Have you ever taken
Fen-Phen? |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV+, AIDS | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> No |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stroke | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tattoos | |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid condition | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tumors or growths | |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Ulcer/stomach problems | |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Sexually transmitted diseases | |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Organ transplants | <input type="checkbox"/> Other, please explain: _____ | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pain in or near ears | <i>If female, please answer the following:</i> | |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Taking birth control pills | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric conditions | <input type="checkbox"/> Pregnant: if so, how many months? _____ | |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Nursing | |

Allergies (please mark all that apply):

- | | | | |
|----------------------------------|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals | |
| <input type="checkbox"/> Jewelry | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Local anesthetics | |

Is there any other information the dentist should know? _____

I attest to the accuracy of the information on this form and hereby authorize Dr. Benavent or designated staff to perform necessary dental treatment mutually agreed upon by me as may be required for proper dental care.

Signature _____ Date _____