AUSTIN DENTAL ASSOCIATES

PATIENT REGISTRATION

TODAY'S DATE ___________________________________

PATIENT INFORMATION

NAME ____ **BIRTHDATE** _____ /______ /_________

ADDRESS ______________________________ **CITY** ________________________ **ZIP** ______________

SEX M F **HOME PHONE** (______)__________________ **SS#** ______________________________

CELL PHONE (_______)________________ **EMPLOYER** ______________________________________

WORK PHONE (_______)________________

Are any family members current patients? □ yes □ no Name __________________________________

Whom may we thank for referring you? ____

EMERGENCY CONTACTS NAME________________________ PHONE (_______)________________

NAME________________________ PHONE (_______)________________

POLICY HOLDER INFORMATION

Policy holder, in case of minor child, custodial parent or legal guardian. This person is responsible to Austin Dental for all charges not covered by insurance incurred by patient listed above.

RESPONSIBLE PARTY NAME ______________________________ **BIRTHDATE** _____ /______ /_________

ADDRESS ______________________________ **CITY** ________________________ **ZIP** ______________

SEX M F **CELL PHONE** (______)__________________ **SS#** ______________________________

EMPLOYER____________________________________ **WORK PHONE** (_______)________________

SPOUSE'S NAME ___________________________________ **BIRTHDATE** _____ /______ /_________

EMPLOYER____________________________________ **WORK PHONE** (_______)________________

INSURANCE INFORMATION

PRIMARY

Policy Holder ____________________________

Birth Date _______________________________

Insurance Company ________________________

Group # __________________________________

ID#/SS# _________________________________

Insurance Phone # __________________________

SECONDARY

Policy Holder ____________________________

Birth Date _______________________________

Insurance Company ________________________

Group # __________________________________

ID#/SS# _________________________________

Insurance Phone # __________________________

…….FORM CONTINUES ON BACK SIDE…………………………………..

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

Condition			Condition		
Penicillin allergy	Yes	No	Hepatitis	Yes	No
Hypoglycemia /Diabetes	Yes	No	Rheumatic Fever	Yes	No
Heart attack / trouble	Yes	No	Anemia / Blood Disorder	Yes	No
Hay fever / Asthma	Yes	No	Excessive Bleeding	Yes	No
High Blood Pressure	Yes	No	Fainting / Blackouts	Yes	No
Circulatory Problems	Yes	No	Nervous Disorders	Yes	No
Hepatitis / Jaundice	Yes	No	Headaches / Migraines	Yes	No
Exposure to AIDS / HIV	Yes	No	Kidney Problems	Yes	No
Lung problems / Tuberculosis	Yes	No	Abnormal Heart Condition	Yes	No
Epilepsy / Seizures	Yes	No	Are you pregnant now?	Yes	No
Blood Transfusions	Yes	No	**Prosthetic Devices**	Yes	No
Facial or Head Injuries	Yes	No	i.e. Hip / Knee replacement		
Radiation Treatments	Yes	No	Denture / Partial	Yes	No
Malignancies / Cancer	Yes	No	Osteoporosis Medication	Yes	No
Sinus Problems	Yes	No	i.e. Fosomax, Zometa, Boniva		
Stroke	Yes	No			
Heart Murmur	Yes	No	Do you need to **Premedicate**?	Yes	No

Have you had unfavorable reactions / allergies to any of the following? Please circle

LATEX / CODEINE / ANESTHETICS / ASPIRIN / SEDATIVES / PENICILLIN / OTHER ________________________

List any medications currently being taken:____

Have you noticed any of the following? Circle if yes

Teeth tender to chew on
Discomfort in face, head neck
Food caught between teeth
Sensitivity to sweets
Bleeding or sore gums
Recurring sore in or around mouth
Jaw clicking or popping
Sensitivity to hot or cold
Swelling/lumps in mouth

Name and telephone of Physician *if being treated now* ____

Name and telephone of previous dentist ____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Austin Dental Associates. I understand that I am financially liable to the dentists for charges not covered by my insurance company. To the best of my knowledge, all information on this form is true and correct. A 1.5% monthly interest charge will be added to unpaid balances over 60 days. In consideration of services provided, I am agreeing to pay for services provided to me, to my spouse, and to my minor children. I/we agree to pay all charges not covered by insurance.

The above information is correct to the best of my knowledge. I give my consent to have the necessary treatment recommended for my benefit (or my minor).

ALL COPAYS ARE DUE AT TIME OF SERVICE

SIGNATURE ____ **DATE** __________________________