HEALTH HISTORY & REGISTRATION

DATE _____

PATIENT NAME _____ BIRTH DATE _____ AGE _____

FULL TIME STUDENT YES _____ NO _____ SCHOOL NAME _____

HOME ADDRESS _____ CITY _____ ZIP _____

MARITAL STATUS: S M W D (PLEASE CIRCLE) M or F SS # OF PATIENT _____

DRIVER'S LIC # _____ HOME PHONE _____

EMPLOYER OF PATIENT OR PARENT _____

CELL PHONE _____ WORK PHONE _____

PERSON RESPONSIBLE FOR BILL & RELATIONSHIP TO PATIENT _____

SS # OF RESP. PERSON _____ DRIVER'S LIC # _____

DENTAL INSURANCE YES ____ NO ____ INSURED'S NAME _____ BIRTHDATE _____

INSURED'S EMPLOYER _____ INSURANCE CO _____ SS # _____

SECOND DENTAL INSURANCE YES ____ NO ____ INSURED'S NAME _____ BIRTHDATE _____

INSURED'S EMPLOYER _____ INSURANCE CO _____ SS # _____

HEALTH HISTORY

Your Weight_____

Do you have a current medical problem? YES ❑ NO ❑ What _____

Have you ever had any of the following?

- ❑ Asthma
- ❑ Arthritis, sore joints
- ❑ Blood trouble, anemia, leukemia
- ❑ Diabetes
- ❑ Excessive bleeding
- ❑ Fainting spells, convulsions, epilepsy
- ❑ Food allergies; list_____
- ❑ Headaches when lying down
- ❑ AIDS/ARC/HIVPos
- ❑ Heart attack
- ❑ Heart murmur
- ❑ Hepatitis, liver disease, jaundice
- ❑ High blood pressure
- ❑ Kidney trouble
- ❑ Lung trouble (TB, emphysema)
- ❑ Mitral valve prolapse
- ❑ Nervous breakdown, psychotherapy
- ❑ Pain, pressure or tightness in chest
- ❑ Rheumatic fever
- ❑ Shortness of breath
- ❑ Swelling of ankles or feet
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ VD (syphilis, gonorrhea)
- ❑ X-ray, indium, cobalt treatments

Are you now:

- ❑ Pregnant_____months?
- ❑ On a prescribed diet
- ❑ Under the care of a physician
- ❑ Using Thyroids
- ❑ Using hormones (including birth control)
- ❑ Using anticoagulents (blood thinner)
- ❑ Using Dilantin
- ❑ Using other medicines (please specify) _____

Are you now taking or using medicines for:

- ❑ Allergy; what_____
- ❑ Arthritis or rheumatism
- ❑ Blood (liver, iron pills)
- ❑ Diabetes (pills or shots)
- ❑ Headaches
- ❑ Heart or blood pressure (digitalis, nitroglycerin, resorpin)
- ❑ Nerves (tranquilizers)
- ❑ Sleeping
- ❑ Stomach trouble (ucler, other)

Have you ever been sick from, shown an allergy to, or told not to take:

- ❑ Antibiotics; what_____
- ❑ Aspirin
- ❑ Codeine
- ❑ Novocaine (or other dental anesthetic)
- ❑ Other drugs or medicines (please specify) _____

Have you been in contact with someone who has AIDS? YES ❑ NO ❑

Have you ever had a tumor or cancer? YES ❑ NO ❑ Where? _____

Have you ever had a major operation? YES ❑ NO ❑ What kind? _____

Have you ever been involved in a serious accident? YES ❑ NO ❑ Describe: _____

DENTAL HISTORY

HOW LONG SINCE you have seen a Dentist? MONTH_____ YEAR_____

	YES	NO
Are you having PROBLEMS now?	❑	❑
Is your present dental health POOR?	❑	❑
Do you wear DENTURES? (Partials or Full)	❑	❑
Have you had any PERIODONTAL (Gum) treatments?	❑	❑
Do your gums BLEED, or feel TENDER or IRRITATED?	❑	❑

	YES	NO
Would you like to know more about PERMANENT REPLACEMENTS?	❑	❑
Are your teeth SENSATIVE to hot, cold, sweets, pressure? (circle)	❑	❑
Do you have HEADACHES, EARACHES or NECK PAINS?	❑	❑
Are you aware of GRINDING or CLENCHING your teeth?	❑	❑

Date: _____ DENTIST Signature _____

BY WHOM WERE YOU REFERRED:

NEWSPAPER_____ CABLE-CHANNEL 13, 6_____ FRIEND_____ YELLOW PAGES_____
OTHER_____

OUR TERMS ARE CASH AND / OR YOUR DENTAL INSURANCE

METHOD OF PAYMENT **(CIRCLE)**

1. CASH OR CHECK 2. VISA 3. MASTER CARD 4. INSURANCE

PAYMENT POLICY

PLEASE READ & SIGN & DATE

Our policy concerning payment for services is Cash and/or Dental Insurance. If you have dental insurance, we will need your booklet on your insurance and it must be verified before using it. We collect at the time of the services what we, to the best of our knowledge, can determine your insurance is not going to pay. But it must be understood that you are responsible to Midfield Dental Center for the charges. We will be happy to file your insurance and await payment from the insurance company, but we will require that you pay any part that your insurance company is not going to pay at the time the services are rendered and also that you understand that we cannot guarantee anything that your insurance company may or may not do involving payment; therefore, there may be a balance owing after your insurance company has determined benefits for any particular claim.

I (we) understand that I (we) are responsible for any charges for services performed by dentists of Midfield Dental Center, and understand we may be billed after our insurance company has either made payment or denied for any of these services.

THERE WILL BE A $37.00 BROKEN APPOINTMENT FEE IF NOT GIVEN A 24 HOUR NOTICE. IF RECORDS ARE TO BE TRANSFERRED TO ANOTHER DOCTOR'S OFFICE THERE WILL BE A $5.00 DUPLICATING FEE.

I (WE) AGREE TO PAY REASONABLE ATTORNEY'S FEES, COURT COSTS, AND OTHER COSTS OF COLLECTION INCURRED IN ANY EFFORT BY PROFESSIONAL DENTAL SERVICES TO COLLECT FOR SERVICES RENDERED TO ME (US).

_____ _____

Signature of Responsible Party Date

PERMISSION FOR DENTAL SERVICES UPON A MINOR

DATE_____

PATIENT _____

RESPONSIBLE PARTY _____

I, BEING THE PARENT (OR GUARDIAN) OF SAID MINOR PATIENT, DO HEREBY AUTHORIZE AND REQUEST THE PERMISSION OF DENTAL SERVICES UPON THIS PATIENT, AND TO DO WHATEVER PROCEDURES THAT THE JUDGMENT OF THE P.D.S. DOCTOR MAY DICTATE DURING TREATMENT.

I DO ALSO AUTHORIZE AND REQUEST THE ADMINISTRATION OF SUCH ANESTHETICS OR SEDATIVES AS MAY BE DEEMED ADVISABLE BY THE P.D.S. DOCTOR.

SIGNATURE_____