

### About You

NAME: \_\_\_\_\_

                    Last First MI Me  
Mrs. Ms Dr

I prefer to be called: \_\_\_\_\_ Male Female

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_\_\_

\_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Partner

Home Address: \_\_\_\_\_

City State Zip

E-Mail Address: \_\_\_\_\_

Home#: ( ) \_\_\_\_\_ Cell#: ( ) \_\_\_\_\_

Work#: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ Fax#: \_\_\_\_\_

Where and when are best times to reach you? : \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_  
(Please Circle)

### Responsible Party Information

Person Responsible for Account: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Relationship: \_\_\_\_\_

Employer: \_\_\_\_\_

Work #: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ SS#: \_\_\_\_\_

Emergency Contact  
(Relative or Friend not living with you)

His/ Her Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: ( ) \_\_\_\_\_ Work#: ( ) \_\_\_\_\_

### Primary Insurance

Dental Coverage? \_\_\_ Yes \_\_\_ No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: ( ) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

### Secondary Insurance

Dental Coverage? \_\_\_ Yes \_\_\_ No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: ( ) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

Payment is due in full at the time of treatment  
Unless prior arrangements have been approved.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. Payment is expected at the time of service. A finance charge of 1.5% per month, 18% annual rate will be charged on balances 30 days past due. I authorize and request my insurance company to pay to DR. ROSS directly. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am responsible for any and all collection fees.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Registration form

### Medical History

Do you have a personal physician?  YES  NO  
 Physician's Name: \_\_\_\_\_  
 Phone#: ( ) \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Your current Physical health is:  Good  Fair  Poor  
 Are you currently under the care of a physician?  YES  NO  
 Please explain: \_\_\_\_\_

Do you smoke or use tobacco?  YES  NO  
 Have you had any metal work, pins or implants?  YES  NO  
 Are you taking any prescriptions/over the counter drugs?  YES  NO

Please list each one: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had any of the following diseases or medical problems:

Y N Abnormal Bleeding	Y N Hepatitis
Y N AIDS	Y N Herpes/ Fever Blisters
Y N Alcohol/ Drug Problems	Y N High Blood Pressure
Y N Anemia	Y N HIV
Y N Arthritis	Y N Hospitalized
Y N Artificial Bones/ Joints	Y N Kidney problems
Y N Asthma	Y N Liver Disease
Y N Blood Transfusion	Y N Low Blood Pressure
Y N Cancer	Y N Mitral Valve Prolapse
Y N Colitis	Y N Pacemaker
Y N Congenital Heart Defect	Y N Psychiatric Problems
Y N Diabetes	Y N Radiation Treatment
Y N Difficulty Breathing	Y N Rheumatic/Scarlet Fever
Y N Emphysema	Y N Seizures
Y N Epilepsy	Y N Shingles
Y N Fainting Spells	Y N Sickle Cell Disease
Y N Headaches	Y N Sinus Problems
Y N Glaucoma	Y N Stroke
Y N Hay Fever	Y N Thyroid Problem
Y N Heart Attack/ Surgery	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers
Y N Hemophilia/Blood Disorders	Y N Venereal Disease

Please list any serious Medical Condition (s) that you have ever had: \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry/Metal	Y N Tetracycline
Y N Latex	Y N Dental Anesthetics	

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_  
 \_\_\_\_\_

### Authorization and Release of Photographs and Diagnostic Materials

I authorize and release DR. ROSS to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, education and advertising and marketing. I also authorize DR. ROSS to use displays intended for promotional purposes without the expectation on any compensation or financial gain.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Dental History

Why have you come to the dentist today?

Are you Currently in pain?  YES  NO  
 Describe: \_\_\_\_\_

Do you require Antibiotics before dental treatment? \_\_\_\_\_

Your current Dental health is:  Good  Fair  Poor

Have you ever had a serious /Difficult problem associated with any dental work?  YES  NO

Do you floss daily?  YES  NO

Brush Daily?  YES  NO

Type of brushes on toothbrush?  Hard  Medium  Soft

Have you ever had gum treatment?  YES  NO

Do your gums ever bleed?  YES  NO

Have you ever had periodontal disease?  YES  NO

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ) / TMD?  YES  NO

Are your teeth sensitive to heat, cold or anything else? \_\_\_\_\_

Do you have mobility in your teeth?  YES  NO

Do you still have wisdom teeth?  YES  NO

Would you like fresher breath?  YES  NO

Would you like whiter teeth?  YES  NO

Are you happy with your smile?  YES  NO

If no, what would you change? \_\_\_\_\_

### For Women

Are you taking birth control pills?  YES  NO

Are you taking Hormones?  YES  NO

Are you pregnant? Week # \_\_\_\_\_  YES  NO

Are you nursing?  YES  NO

### Authorization and Release

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence in compliance with HIPPA and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_