Drs. Delaney, Plunkett, Ralstrom, Makowski, Thanasas, Ker & Associates, P.C.

PATIENT REGISTRATION

Account No. _____

Date _____

Patient Information

Birthdate (Mo., Day, Year)			
Patient's Last Name	First Name	Middle Initial	(Area Code) Home Phone
Street Address	City, State, Zip Code		(Area Code) Cell #
Employed By	Business Address		(Area Code) Business Phone
Patient's Social Security #	(Area Code) Fax #		Job Position
Patient's Dental Insurance	Group #		Insurance ID #
Patient's Email Address			

Spouse's Information

Birthdate (Mo., Day, Year)			
Spouse's Last Name	First Name	Middle Initial	(Area Code) Home Phone
Street Address	City, State, Zip Code		(Area Code) Cell #
Employed By	Business Address		(Area Code) Business Phone
Spouse's Social Security #	(Area Code) Fax #		Job Position
Spouse's Dental Insurance	Group #		Date Insurance Effective
Patient's Email Address			

OVER

Emergency Information

Person to be reached in case of emergency, other than parent:

Name	Relationship to Patient	(Area Code)Phone Number
Name	Relationship to Patient	(Area Code)Phone Number

Consent For Treatment

By signing your consent below, you are giving the Doctors permission to perform a dental examination including x-rays (periapical, bitewing, occlusal, panoramic, and/or cephalometric, radiographic films), photographs, and/or models. This authorization also includes all necessary treatment, medications and therapy indicated for dental care. The doctors are also given permission to use their professional judgement in patient management regimes as they feel necessary.

My dentist has explained the risks of the proposed treatment, and any alternative treatment available. I have been allowed to ask any questions I have, and have received satisfactory answers to those question, if any.

I authorize release of information to my insurance carrier. I authorize payment directly to the doctor from my insurance carrier.

I understand and agree that, (regardless of my insurance status), I am responsible for the balance on my account at the time professional services are rendered. I understand it is my responsibility to pay all fees not covered by my insurance. I understand it is my responsibility to pay all costs associated with collection of unpaid and overdue balances including the costs associated with collection agencies should such action be indicated. I have read all of the information and have completed this form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes.

I AUTHORIZE _____ TO HAVE ACCESS TO

MY HEALTH INFORMATION AND TO TALK TO MY INSURANCE CARRIER ON MY BEHALF.

SIGNATURE _____ DATE _____

DENTAL ASSISTANT _____

Medical History

Patient's Name_____ Date of Birth_____

Family Physician_____ Office Phone Number_____

Family Dentist_____ Whom may we thank for referring you? _____

Do you have any dental complaints?_____

General health (please check) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Last complete physical?_____ Findings?_____

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

Have you had any serious operations, illnesses, injuries and/or hospitalizations? ☐ Yes ☐ No

If yes, please list dates and reasons_____

_____

_____

Are you taking any medication now? ☐ Yes ☐ No If yes, please list the names of the medication, dosage and purpose: _____

_____

_____

Are you taking any form of Contraceptive Medication (i.e., birth control pills) at this time? (Prescription of certain antibiotics may interfere with the effectiveness of the birth control medication.) ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Are you allergic to:

☐ Yes ☐ No Latex
☐ Yes ☐ No. Penicillin/Amoxicillin
☐ Yes ☐ No Sulfa medications
☐ Yes ☐ No Codeine
☐ Yes ☐ No Local anesthetics
☐ Yes ☐ No Other?_____

Do you have a history of any of the following?

☐ Yes ☐ No Heart disease/disorders
☐ Yes ☐ No Rheumatic fever
☐ Yes ☐ No Abnormal blood pressure
☐ Yes ☐ No Blood disorders/dyscrasias
☐ Yes ☐ No Anemia
☐ Yes ☐ No Prolonged bleeding
☐ Yes ☐ No Bruise easily
☐ Yes ☐ No Blood transfusion
☐ Yes ☐ No Lung disease
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Respiratory infections
☐ Yes ☐ No Coughing
☐ Yes ☐ No Asthma
☐ Yes ☐ No Sinus trouble
☐ Yes ☐ No Allergies
☐ Yes ☐ No Liver disease
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Pancreatic disease
☐ Yes ☐ No Endocrine disorders
☐ Yes ☐ No Thyroid disorder
☐ Yes ☐ No Kidney/bladder disease
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Stomach/GI problems
☐ Yes ☐ No Cancer/tumors
☐ Yes ☐ No Chemotherapy/ radiation
☐ Yes ☐ No Neurological disorders
☐ Yes ☐ No Recurrent headaches
☐ Yes ☐ No Epilepsy/Seizures
☐ Yes ☐ No Skin disease/disorders
☐ Yes ☐ No Bacterial/viral infections
☐ Yes ☐ No STD's/ Herpes
☐ Yes ☐ No AIDS/HIV
☐ Yes ☐ No Anorexia/Bulimia
☐ Yes ☐ No Congenital birth defects
☐ Yes ☐ No Cleft lip/Cleft palate
☐ Yes ☐ No Mental Impairment
☐ Yes ☐ No Developmental delays
☐ Yes ☐ No Learning problems
☐ Yes ☐ No Emotional problems
☐ Yes ☐ No Physical handicaps
☐ Yes ☐ No Vision problems
☐ Yes ☐ No Hearing problems

OVER

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PERSONAL HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

_____

Please print patient's name(s)

_____ _____

Please print your name | Please sign your name

_____ _____

Legal Representative | Description of Authority

Your comments regarding Acknowledgements or Consents: _____

Your email address: _____

FOR PATIENT USE