



REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Name _____ Today's Date _____

Address _____ City, State & Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Email _____ Social Security # _____

Marital Status (please check box): Single [], Married [], Widowed [], Divorced [], Other []

Have other members of your family been to our office? Yes [], No []

Referred to our office by: _____

Physician's Name: _____ Phone #: _____

Pharmacy _____ Phone # _____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party (guardian) _____ Social Security # _____

Address (if different than patient) _____

Occupation _____ Employer _____ Employer / Work Phone _____

RESPONSIBLE PARTY'S SPOUSE

Name of Responsible Party's Spouse _____ Social Security # _____

Address (if different than patient) _____

Occupation _____ Employer _____ Employer / Work Phone _____

DENTAL INSURANCE

Insurance Company _____ Insured Name _____

Insured DOB _____ Subscriber Number _____

Group # _____ Employer _____

Insurance Co. Address _____

Insurance Co. Phone # _____

SECONDARY DENTAL INSURANCE

Insurance Company _____ Insured Name _____

Insured DOB _____ Subscriber Number _____

Group # _____ Employer _____

Insurance Co. Address _____

Insurance Co. Phone # _____

EMERGENCY CONTACT

Name of Relative or Spouse _____ Relationship _____ Phone _____

Address _____

Do we have permission to discuss your dental information with your spouse or family? [] YES [] NO

If yes, who? _____

Sex ____ if, female please answer the following questions:
Are you taking birth control pills? [] YES [] NO
Are you pregnant? [] YES [] NO
If yes, number of weeks? _____
Are you nursing? [] YES [] NO
If yes number of weeks? _____

Do you smoke? [] YES [] NO

Weight _____

Height _____

Please check if you have any of the following conditions/allergies:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> GERD | <input type="checkbox"/> Pneumocystitis | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Dental Anesthetics |
| <input type="checkbox"/> Cancer-Chemotherapy | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Jewelry |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Seizures | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Shingles | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> HIV + AIDS | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid Problems | |

Please list any allergies that you have that were not listed above:

Please list any prescription and non prescription medication that you are currently taking: _____

Have you ever been hospitalized [] YES [] NO If yes, what for: _____

Please list any surgeries you have had: _____

Has a prior dentist or physician ever informed you that an antibiotic (pre-medication) should be taken prior to dental work?

[] YES [] NO

[] YES [] NO Do you have any diseases, conditions, or problems that were not covered above? If yes, please describe below:

I hereby authorize Fox Dentistry to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

Missed/cancelled appointments: Failure to not show or notify us for a scheduled appointment will result in a broken appointment fee.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

Responsibility for Payment: In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection of sums due and unpaid for the work herein set forth.

Signature _____ Date _____