



Patient Registration

Name: _____ Preferred Name: _____
Last First MI

Title: _____ Gender: M or F Family Status: Married, Single, Child
Mr, Mrs, Ms, Dr, etc

DOB: _____ S. S. # _____ Email Address: _____

Phone: _____ Best time to call: _____
Home work mobile

Address: _____ City: _____ State: _____ Zip: _____

The following is for the: patient___ or the person responsible for payment___

Employer name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse Name: _____ Phone: _____

Spouse's Employer: _____ Phone: _____

Name of Insured: _____ DOB of Insured: _____

ID #: _____ Group: _____

Insured's Address: _____

Insured's Employer Name: _____

Employer Address: _____

Relationship to patient: self____, spouse____, child____, other____

Insurance Plan: _____ Address: _____

Physician's Name: _____ Phone #: _____

How did you hear about our office? _____

What is most important about your smile, dental health and/or teeth? _____

What would you like to accomplish with today's visit? _____

Health History

Indicate which of the following you have or have had by circling **Yes** or **No**.

Pre- Med Amox	Y	N	Pre-Med-Clind	Y	N	Pre-Med Other	Y	N
Allergies	Y	N	Allergy-Aspirin	Y	N	Allergy-Codeine	Y	N
Allergy-Erythro	Y	N	Allergy-Hay Fever	Y	N	Allergy-Latex	Y	N
Allergy-Other	Y	N	Allergy-Penicillin	Y	N	Allergy-Sulfa	Y	N
Anemia	Y	N	Arthritis	Y	N	Bisphosphonates	Y	N
Artificial Joints	Y	N	Asthma/Emphysema	Y	N	Cancer	Y	N
Blood Disease	Y	N	Blood Thinners	Y	N	Dizziness	Y	N
Chemotherapy Tx	Y	N	Diabetes	Y	N	Excessive Bleeding	Y	N
Drug Addiction	Y	N	Epilepsy/Seizures	Y	N	Head Injuries	Y	N
Fainting	Y	N	Glaucoma	Y	N	Heart/Valve Surgery	Y	N
Heart Disease	Y	N	Heart Murmur	Y	N	HIV	Y	N
Hepatitis	Y	N	High Blood Pressure	Y	N	Liver Disease	Y	N
Jaundice	Y	N	Kidney Disease	Y	N	Nervous Disorders	Y	N
Lupus	Y	N	Mental Disorders	Y	N	Radiation Treatment	Y	N
Other	Y	N	Pacemaker	Y	N	Rheumatism	Y	N
Respiratory Problems	Y	N	Rheumatic Fever	Y	N	Stroke	Y	N
Sinus Problems	Y	N	Stomach Problems	Y	N	Tobacco Products	Y	N
Thyroid	Y	N	TMJ	Y	N	Ulcers	Y	N
Tuberculosis	Y	N	Tumors	Y	N			
Are you pregnant?	Y	N	If yes, what month? _____			Are you nursing?	Y	N

List **ALL** medications and herbal supplements: _____

Do you have any heart conditions or joint replacements that require premedication? _____

Any other conditions we should be aware of? _____

Previous Dentist: _____

How long since your last dental visit? _____

We understand that a situation may arise that could force you to postpone your treatment. Please understand that such changes affect not only your dentist but our ability to help other patients. Dr Márquez's time, as well as that of our staff, is a precious commodity and we request your courtesy and respect. A \$50 administrative fee will be charged to patients who habitually change or cancel their appointments within 48 hours of their scheduled visit.

I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I further understand that a collection fees may be added to overdue balances.

I authorize release of any information for insurance, medical or dental purposes.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

Signature: _____ Date: _____

Patient/Guardian

Signature: _____ Date: _____

Doctor