PHELPS & PHELPS, D.D. S., P.A. HEALTH HISTORY & REGISTRATION

TODAY'S DATE: ______________________

PATIENT'S NAME: Last ______________________ First ______________________ Middle Initial ________ SEX: M F BIRTHDATE ____________ AGE ________

Soc. Sec. # ______________________ If Patient is a Minor, give Parent or Guardian's Name ______________________ # where you can be reached ______________

Who May We Thank for Referring You to our Office? ______________________ Reason for this Visit ______________________

RESPONSIBLE PARTY INFORMATION

NAME: Last ______________________ First ______________________ Middle ______________ MARITAL STATUS ____________

RESIDENCE: Street ______________________ Apt. # __________ City ______________________ State __________ Zip __________

MAILING ADDRESS: Street ______________________ Apt. # __________ City ______________________ State __________ Zip __________

HOW LONG AT THIS ADDRESS ______ HOME PHONE ______________ WORK PHONE ______________ EMAIL ADDRESS ______________

PREVIOUS ADDRESS (if less than 3 years) Street ______________________ City ______________ State ______ Zip __________ How Long __________

SOCIAL SECURITY # ______________ BIRTHDATE ______________ DRIVER'S LICENSE # ______________ RELATION TO PATIENT ______________

EMPLOYER ______________________ OCCUPATION ______________________ NO. YEARS EMPLOYED ____________

RESPONSIBLE PARTY'S SPOUSE

NAME ______________________

EMPLOYER ______________________ NO. YEARS EMPLOYED ______

OCCUPATION ______________ SOC. SEC. # ______________

WORK PHONE ______________ BIRTHDATE ______________

EMERGENCY INFORMATION: PLEASE LIST A LOCAL CONTACT *(Not living with you)*

NAME ______________________ RELATIONSHIP ______________

ADDRESS ______________________

CITY/STATE/ZIP ______________________ PHONE # ______________

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ______________________

Insurance Company ______________________

Insurance Company Address ______________________

Insured's Employer ______________________

Insured's Soc. Sec. # ______________ Group # ______________

Insured's Date of Birth ______________________

- SECONDARY COVERAGE -

Filed as a courtesy. NOT ACCEPTED as a Copay.

Insured's Name ______________________

Insurance Company ______________________

Insurance Company Address ______________________

Insured's Employer ______________________

Insured's Soc. Sec. # ______________ Group # ______________

Insured's Date of Birth ______________________

PAYMENT ALTERNATIVES (Please check appropriate box:)

☐ 1. Cash and personal checks are accepted as your treatments are provided.

☐ 2. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment and will gladly file your claims. This means that you are responsible for your deductible and your estimated copayment at time of treatment. Remember that you are still responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

☐ 3. Mastercard, Visa and Discover.

☐ 4. For long term or extended payments, we offer a healthcare financing program, which when you are accepted, will allow extended small monthly payments for the treatment received.

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a 1.5% service charge will be added to any overdue balance each month. I also understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) ______________________ Date: ____________ DENTIST Signature ______________________

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking time to completely fill out this questionnaire.

DENTAL HISTORY

	YES	NO
HOW LONG SINCE you have seen a Dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, Date: (18 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist: City: State:

MEDICAL HISTORY

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For What?		
What MEDICATIONS are you currently taking?		
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	Heart Surgery	Liver Disease	Chemotherapy (Cancer, Leukemia)	Allergies or Hives
Angina Pectoris	Artificial Joints	Blood Transfusion	Venereal Disease (Syphilis, Gonorrhea, etc.)	Diabetes
High Blood Pressure	Anemia	Drug Addiction		Thyroid Disease
Heart Murmur	Stroke	Hemophilia (Bleeding Problems)	Bruise Easily	Radiation Treatment
Rheumatic Fever	Kidney Trouble	Fever Blisters	Emphysema	Arthritis
Congenital Heart Lesions	Ulcers	Epilepsy or Seizures	Tuberculosis (TB)	Cortisone Medicine
Mitral Valve Prolapse	A.I.D.S./A.R.C./HIV Positive	Nervousness	Asthma	Pain in Jaw Joints
Artificial Heart Valve	Hepatitis A (infectious)	Psychiatric Treatment	Hay Fever	Alcoholism
Heart Pacemaker	Hepatitis B (serum)	Glaucoma	Sinus Trouble	Cosmetic Surgery

Are you allergic to or have you reacted adversely to any of the following medications?

Aspirin Local Anesthetic Erythromycin Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances? ____________________

If yes, please list: ____________________