REGISTRATION / HEALTH HISTORY for Allegan Family Dentistry

DATE _____

REASON FOR APPOINTMENT

HOW MAY WE BE OF SERVICE TO YOU? _____

PATIENT INFORMATION

PATIENT'S NAME_____ Preferred "Nickname" (if applicable) _____

NAME OF SPOUSE (IF APPLICABLE)_____

IF A CHILD, PARENT'S NAME_____

PATIENT'S ADDRESS_____ CITY _____ STATE _____ZIP _____

CELL PHONE_____WORK PH_____ HOME PH _____ EMAIL _____

CHECK IF DO ***NOT*** WANT TEXT/EMAIL MESSAGE APPOINTMENT CONFIRMATIONS____(IF UNCHECKED WE WILL ASSUME OK)

MARITAL STATUS_____ DATE OF BIRTH _____ AGE _____

PATIENT'S SOCIAL SECURITY #_____ SEX _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

ACCOUNT GUARANTOR INFORMATION

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT? _____

NAME OF EMPLOYER_____ CITY/STATE/ZIP _____

DO YOU HAVE DENTAL INSURANCE? YES____ NO_____ ***IF YES***: *PLEASE COMPLETE THE FOLLOWING ALSO:*

NAME OF DENTAL INSURANCE CARRIER_____ GROUP #_____

IF YOU HAVE DENTAL INSURANCE THROUGH SOMEONE OTHER THAN THE PATIENT:

NAME OF EMPLOYEE/SUBSCRIBER_____ SUBSCRIBER RELATIONSHIP TO PATIENT_____

SUBSCRIBER DATE OF BIRTH _____ SUBSCRIBER ID/CONTRACT #_____

SUBSCRIBER SOCIAL SECURITY # _____(SOME INSURANCES ONLY USE SS# FOR BILLING)

HOME ADDRESS(ONLY IF DIFFERENT THAN PATIENT'S)_____ CITY/STATE/ZIP _____

IF YOU HAVE SECONDARY DENTAL INSURANCE COVERAGE, PLEASE COMPLETE THE FOLLOWING:

EMPLOYEE/SUBSCRIBER NAME_____ SUBSCRIBER BIRTHDATE _____ EMPLOYER_____

SUBSCRIBER RELATIONSHIP TO PATIENT _____ SUBSCRIBER SOCIAL SECURITY #_____

SUBSCRIBER ADDRESS_____ CITY/STATE/ZIP _____

☺ **OVER PLEASE** ☺

HEALTH QUESTIONNAIRE — *confidential*

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE .... YES____ NO____ IF SO, FOR WHAT?_____

PLEASE LIST ALL CURRENT MEDICATIONS? _____

WHEN WERE YOU LAST SEEN BY YOUR PHYSICIAN?_____ FOR WHAT?_____

WHAT IS YOUR PHYSICIAN'S NAME & PHONE NUMBER? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS (if so, please list)? _____

HAVE YOU EVER HAD COMPLICATIONS WITH "SHOTS" (LOCAL ANESTHETICS), SEDATIVES, ANTIBIOTICS, PAIN MEDS OR ANY OTHER DRUG?_____ DO YOU HAVE CHEST PAIN ON EXERTION? _____

HAVE YOU EVER TAKEN ORAL OR I.V. BISPHOSPHATE DRUGS (example: Fosamax, Actonel, Aredia, Boniva)?_____
If so, indicate whether IV or oral meds, name of med & amount of time taken?_____

HAVE YOU HAD SURGERY WITHIN THE PAST SIX MONTHS (if so, for what?)_____

PLEASE CIRCLE ALL OF THE FOLLOWING THAT PERTAIN TO YOU PAST OR PRESENT:

Pregnant Now	High Blood Pressure	Diabetes Mellitus/Hypoglycemia	Latex Allergy
Hepatitis/Liver Disease	Allergy to Metals	Heart Disease/Attack	Allergy to Bisulfate
Infective Endocarditits	Stent/Pacemaker	Dry Mouth	Dialysis
Blood Disease/Prolonged Bleeding	Medical Marijuana Use	Total Joint Replacement	Allergy to Milk Protein
Recreational Drug Use	Alcohol	Acid Reflux	Migraines/Headaches
Cancer	Tuberculosis (TB)	AIDS / HIV	Artificial Heart Valve
Fainting Spells	Asthma-Breathing Issues	Epilepsy or Seizures	Stroke
Tobacco Use	Other:(Specify)_____		

WHAT DO YOU WANT ACCOMPLISHED IN TERMS OF DENTAL TREATMENT? _____

IF YOU COULD CHANGE YOUR SMILE/TEETH, WHAT WOULD YOU WANT DONE? _____

IS YOUR GOAL TO KEEP YOUR TEETH LOOKING AND FEELING GOOD FOR YOUR ENTIRE LIFETIME?_____

HAVE YOU EVER REFUSED DENTAL CARE (If so, for what)? _____

HOW LONG SINCE YOUR LAST DENTAL APPT?_____FOR WHAT?_____WHERE?_____

HOW OFTEN DO YOU USUALLY BRUSH?_____FLOSS?_____ ANYTHING ELSE WE SHOULD KNOW?_____

DO YOU HAVE ANY HOBBIES? _____

PLEASE CIRCLE ALL OF THE FOLLOWING THAT PERTAIN TO YOU NOW:

Pain	Swelling	Dry Mouth	Bad Breath Concerns
Hot/Cold/Air Sensitive	Bleeding Gums	Pain on Chewing	Difficulty Chewing/Swallowing
Sores in Mouth	Clicking/Sore Jaw	Broken Tooth	Fever
Fear of Dental Care	Frequent Pop Drinker	Clenching/Grinding	Loose Teeth

I hereby consent to have Dr. Be and his staff provide dental care for me/this patient. I authorize the staff to release any information required to process insurance claims. I assume financial responsibility for all charges incurred & understand that delinquent accounts are charged a monthly finance charge at an annual rate of seven percent. I understand that the office policy is payment at the time of care for services rendered, except where insurance coverage is expected, then the projected patient co-payment is due at the time of service and any balance after insurance payment is received is due within 30 days. I also authorize use of models, radiographs and/or photographs by Dr. Be in publications and presentations.

Signature of Patient (or Guardian) _____ ***Date*** _____