Patient Registration

Patient Information

First Name:_____ Last Name:_____ Middle Initial:___

Preferred Name/Nick Name:_____

Address:_____ City, State, Zip:_____

Phone Number:_____

Birth Date:_____ Age:____ Gender: ○ Male ○ Female

Referred By:_____

Responsible Party/Parent /Legal guardian Information

First Name:_____ Last Name:_____ Middle Initial:___

Address:_____ City, State, Zip:_____

Phone #:_____ Cell #:_____ Work#:_____ext.____

E-mail:_____

Birth Date:_____ Gender: ○ Male ○ Female

Is the Insurance under this Parent/Legal Guardian? ○ Yes ○ No

If no, Please list the Parent/Legal Guardian the insurance is under below.

Responsible Party/Parent /Legal guardian Information

First Name:_____ Last Name:_____ Middle Initial:____

Address:_____ City, State, Zip:_____

Phone #:_____ Cell #:_____ Work #:_____

Birth Date:_____ Gender: ○ Male ○ Female

Emergency Contact (Non Parent/Guardian)

Emergency Contact:_____

Phone #:_____

Relationship to Patient:_____

Primary Insurance

Insured Name:_____

Birth Date:_____

Soc. Sec. #:_____

Insurance Co:_____

Address:_____

City, State, Zip:_____

Employer:_____

Secondary Insurance

Insured Name:_____

Birth Date:_____

Soc. Sec. #:_____

Insurance Co:_____

Address:_____

City, State, Zip:_____

Employer:_____

ATTENTION-PLEASE READ THE FOLLOWING CAREFULLY AND SIGN AT T HE BOTTOM.

*Please be advised if for any reason you/legal guardian cannot bring your child to their scheduled appointment, we MUST have a note signed by you/legal guardi stating we are able to treat you child in the caregivers presence. There are NO exceptions, and your child will not be seen without this note.

*If you need to cancel or reschedule we require a 24 hour notice, if no notice is given, your family account will be subjected to a $25 fee per child failed. We also reserve the right to not reschedule your child back.

*All payments are due upon service date. Any payment arrangements need to be made prior to day of appointment. All accounts past due 90 days will be submi to collections.

Signature_____ Date:_____

Dr. Kurt Halum, D.M.D.

MEDICAL HISTORY

Patient's Name -

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pace Maker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Mental/Physical Disabilities: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____