PATIENT REGISTRATION FORM

NAME ______________________ PREFERRED NAME______________ BIRTHDATE __________
ADDRESS ________________________________ CITY __________________ STATE ______
ZIP __________ PREFERRED PHONE _______________ SOCIAL SECURITY # ______________
MARITAL STATUS__________ SEX (M/F) ________ DENTAL INSURANCE (YES/NO) __________

DENTAL INSURANCE INFORMATION:

INSURANCE COMPANY ______________________ SUBSCRIBER'S NAME _________________
SUBSCRIBER'S BIRTHDATE ___________ SUBSCRIBER'S SOCIAL SECURITY #_______________
SUBSCRIBER'S EMPLOYER ______________________ (PLEASE PROVIDE YOUR INSURANCE CARD)

PLEASE CHECK IF YOUR MEDICAL HISTORY INCLUDES ANY OF THE FOLLOWING CONDITIONS?

_____ 1. ALLERGY TO ANY DRUGS - PLEASE LIST ____
_____ 2. ANEMIA/BLOOD DISEASE
_____ 3. ARTIFICAL JOINTS
_____ 4. ASTHMA
_____ 5. CANCER AND/OR RADIATION TREATMENT
_____ 6. DIABETES
_____ 7. EPILEPSY
_____ 8. HEART DISEASE
_____ 9. HEPATITIS OR HIV
_____ 10. HIGH BLOOD PRESSURE
_____ 11. KIDNEY PROBLEMS
_____ 12. LIVER PROBLEMS
_____ 13. PACEMAKER
_____ 14. CURRENTLY PREGNANT
_____ 15. RESPIRATORY PROBLEMS
_____ 16. SINUS PROBLEMS
_____ 17. STOMACH PROBLEMS
_____ 18. STROKE
_____ 19. TOBACCO USE
_____ 20. TAKING OSTEOPOROSIS DRUGS OR HAVE IN THE PAST (I.E. FOSMAX, ACTONEL, BONIVA)

PLEASE LIST ANY DRUGS YOU ARE TAKING: ______________________________________

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WHEN WAS YOUR LAST DENTAL CHECKUP ______________ XRAYS TAKEN (YES/NO) __________
LAST TREATING DENTIST ____
WHAT IS THE PURPOSE OF YOUR VISIT TODAY?____

EMERGENCY CONTACT_________________ RELATIONSHIP__________ PHONE ____________
FAMILY PHYSICIAN ____________________ OTHER CURRENT PHYSICIANS_______________

I ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SERVICES RENDERED AND AGREE TO PAY FOR THEM, IN FULL. I GIVE MY CONSENT TO BE TREATED BY DR. AMANDA MCCAULEY-THORNBERRY AND HER STAFF.

SIGNED ____________________________ (PATIENT OR PARENT, IF MINOR) DATE ______________