

Patient Registration / History / Billing Information

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____ Age _____

Name (Last, First, Middle) _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Mobile Phone _____

Circle Which Apply: Sex: M / F Minor Single Married Divorced Widowed Separated

Employer _____ Work Phone _____

Business Address _____ Occupation _____

How were you referred: _____

In case of an emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account (Last, First) _____

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Mobile Phone _____

Person Responsible Employer _____ Work Phone _____

Business Address _____ Occupation _____

Dental Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL DENTAL INSURANCE

Insured Name (Last, First) _____

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Mobile Phone _____

Insured Employed By _____ Work Phone _____

Dental Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please Complete Both Sides of this Form

DENTAL HISTORY

Former Dentist _____
City, State _____
Date of Last Dental Visit _____

Date of Last X-Rays _____
How Often Do You Floss? _____
How Often Do You Brush? _____

Check All That Apply:

- Bad Breath
- Bleeding Gums
- Blisters on Lips or Mouth
- Finger Nail Biting
- Grinding Teeth
- Lip or Cheek Biting
- Loose or Broken Fillings
- Orthodontic Treatment
- Pain Around Ear
- Periodontal Treatment
- Sensitivity to Cold
- Sensitivity to Hot
- Sensitivity to Sweets
- Sensitivity When biting
- Frequent Headaches
- Jaw, Head or Neck Injuries
- Jaw Difficulty: Clicking and/or Pain
- Tooth Pain

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

- | | | | | | |
|---|-----|-----|------------------------------------|-----|-----|
| | Yes | No | | Yes | No |
| 1. Are you currently under medical treatment? | ___ | ___ | 7. Any allergic reactions to: | | |
| 2. Have you ever had any serious illnesses or operations? | ___ | ___ | Local Anesthetics (e.g. Novocaine) | ___ | ___ |
| 3. Are you currently taking any medication? | ___ | ___ | Penicillin | ___ | ___ |
| Please Describe: _____ | | | Other Antibiotics | ___ | ___ |
| _____ | | | Sulfa Drugs | ___ | ___ |
| _____ | | | Codeine | ___ | ___ |
| 4. Do you smoke? | ___ | ___ | Sedatives | ___ | ___ |
| 5. Do you use alcohol, cocaine, or other drugs? | ___ | ___ | Iodine | ___ | ___ |
| 6. Do you wear contact lenses? | ___ | ___ | Aspirin | ___ | ___ |
| | | | Other | ___ | ___ |
| | Yes | No | | | |
| 8. Women Only, Are You: | | | | | |
| Pregnant? | ___ | ___ | | | |
| Nursing? | ___ | ___ | | | |
| Taking birth control pills? | ___ | ___ | | | |

Check All That Apply:

- AIDS
- Arthritis, Rheumatism
- Artificial Joints
- Asthma
- Bleeding Abnormally
- Diabetes
- Epilepsy
- Fainting or Dizziness
- Heart Murmur
- Heart Problems
- Hepatitis A/B/C
- Herpes
- High Blood Pressure
- HIV Positive
- Latex Sensitivity
- Kidney Disease
- Mitral Valve prolapse
- Pacemaker
- Radiation Treatment
- Rheumatic Fever
- Sinus Trouble
- Skin Rash
- STD
- Thyroid Problems
- Tuberculosis
- Other / Please List

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Barry N. Stein D.D.S. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ **Date** _____