

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance with \_\_\_\_\_  
*Name of Insurance Company(ies)*

and assign directly to Dr. \_\_\_\_\_ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

\_\_\_\_\_  
*Date* *Signature*

**MINOR/CHILD CONSENT**

I, being the parent or guardian of \_\_\_\_\_ do hereby request  
*Name of Minor/Child*

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

\_\_\_\_\_  
*Date* *Signature of Insured/Guardian*

**FINANCIAL AGREEMENT**

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

\_\_\_\_\_  
*Date* *Signature of Insured/Guardian*

**MEDICAL HISTORY UPDATE**

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what \_\_\_\_\_

\_\_\_\_\_  
*Date* *Patient Signature*

\_\_\_\_\_  
*Date* *Dentist Signature*

**MEDICAL HISTORY UPDATE**

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what \_\_\_\_\_

\_\_\_\_\_  
*Date* *Patient Signature*

\_\_\_\_\_  
*Date* *Dentist Signature*

# PATIENT REGISTRATION AND MEDICAL HISTORY

Date \_\_\_\_\_

(PLEASE PRINT)

Patient \_\_\_\_\_  
Last Name First Name Initial Preferred Name

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Alt. Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Email address: \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_ Spouse/Parent Birthdate \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse/Parent Social Security # \_\_\_\_\_

Name of Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Have you ever had any of the following? (check boxes that apply):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart Problems                    | <input type="checkbox"/> Epilepsy                             | <input type="checkbox"/> Special Diet                                       |
| <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Headaches                            | <input type="checkbox"/> Swollen Neck Glands                                |
| <input type="checkbox"/> Low Blood Pressure                | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Rheumatic Fever                                    |
| <input type="checkbox"/> Circulatory Problems              | <input type="checkbox"/> Cancer                               | <input type="checkbox"/> Sinus Problems                                     |
| <input type="checkbox"/> Nervous Problems                  | <input type="checkbox"/> Psychiatric Care                     | <input type="checkbox"/> HIV / AIDS or<br>Other Immunosuppressive Disorders |
| <input type="checkbox"/> Radiation Treatment               | <input type="checkbox"/> Chronic Diarrhea                     | <input type="checkbox"/> Thyroid Disease                                    |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Allergies to Anesthetics             | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> Recent Weight Loss                | <input type="checkbox"/> Allergies to Medicine or Drugs       | <input type="checkbox"/> Ulcer  |
| <input type="checkbox"/> Back Problems                     | <input type="checkbox"/> General Allergies                    | <input type="checkbox"/> Venereal Disease                                   |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Blood Disease                        | <input type="checkbox"/> Chemical Dependency                                |
| <input type="checkbox"/> Respiratory Disease               | <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Hemophilia   |

Do you have any drug allergies or have you ever had an adverse reaction to any medication? \_\_\_\_\_ If so, please describe \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.  Yes  No

Have you ever responded adversely to medical or dental treatment? \_\_\_\_\_

Are you taking any medication at this time? \_\_\_\_\_ If so, what \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Are you under the care of a physician?  Yes  No For what conditions? \_\_\_\_\_

If patient is a child, what is his/her weight? \_\_\_\_\_

(Women) Do you suspect that you are pregnant?  Yes  No Are you nursing?  Yes  No

Is there anything else we should know about your medical history? \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date \_\_\_\_\_ Signature \_\_\_\_\_