PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Patient _____
Last Name First Name Initial Preferred Name

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail _____

Sex: ___ M ___ F Age _____ Birthdate _____ ___ Single ___ Married ___ Widowed ___ Separated ___ Divorced

Patient Social Security # _____ Occupation _____

Employed By _____ Employer Address _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Social Security # _____ Occupation _____

Spouse/Parent Employed by _____ Employer Address _____

Who is responsible for this account? _____ Relationship to Patient _____

Name of Dental Insurance Company _____ Group# _____

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):

- ❑ Heart Problems
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Circulatory Problems
- ❑ Nervous Problems
- ❑ Radiation Treatment
- ❑ Artificial Heart Valves or Joints
- ❑ Diabetes
- ❑ Respiratory Disease
- ❑ Epilepsy
- ❑ Headaches
- ❑ Hepatitis, Jaundice or Liver Disease
- ❑ Cancer
- ❑ Psychiatric Care
- ❑ Allergies to Anesthetics
- ❑ Allergies to Medicine or Drugs
- ❑ General Allergies
- ❑ Blood Disease
- ❑ Arthritis
- ❑ Rheumatic Fever
- ❑ Sinus Problems
- ❑ "A.I.D.S." or Other Immunosuppressive Disorders
- ❑ Stroke
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Chemical Dependency
- ❑ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what _____

_____

Have you ever responded adversely to medical or dental treatment? _____

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

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 _____

OVER →

Dr. John F. Erhard, III

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
signature *date*

FINANCIAL AGREEMENT

I understand that I am responsible for payment for all services rendered, whether or not paid by insurance. It is my understanding that payment is due at the time of service, unless other financial arrangements have been made. ___(initial)

It is also my understanding that failure to keep appointments and/or failure to give more than 24 hours notice of cancellation will result in a charge that must be paid prior to scheduling another appointment. ___ (initial)

MINOR/CHILD CONSENT

I being the parent or guardian of _____ do
Name of child/minor
Hereby request 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.

_____ _____
signature *date*

INSURANCE CONSENT

I, the undersigned, have insurance with _____ and
Name of insurance company
assign directly to Dr. Erhard all benefits payable to me for services rendered. I authorize the use of this signature on all insurance submissions whether manual or electronic.

_____ _____
signature *date*