NELSON BURY DENTISTRY

PATIENT REGISTRATION

NP PW & CONSENTS

First Name:_____ **Last Name:**_____ **Middle Initial:**_____

Preferred Name:_____ **Patient Is:** ◯Responsible Party ◯Policy Holder

Patient Information

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

Sex: ◯Male ◯Female Marital Status: ◯Married ◯Single ◯Divorced ◯Separated ◯Widowed

Birth Date:_____

If patient is the Responsible Party: Driver's License #:_____ Soc. Sec. #:_____

Your Employer:_____ Your Occupation:_____

Employment Status: ◯Full Time ◯Part Time ◯Retired Student Status: ◯Full Time ◯Part Time ◯N/A

Emergency Contact Name & Phone #:_____

Preferred Pharmacy & Location:_____

Primary Care Physician Name & Phone #:_____

Responsible Party – Account/Payment (If someone other than patient)

Relationship to patient: ◯Spouse ◯Mother ◯Father ◯Guardian ◯Other:_____

Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

Birth Date:_____ Soc. Sec. #:_____ Drivers License #:_____

For children 18 years and younger – Parent Information (If any other than Responsible Party)

◯Mother ◯Stepmother ◯Guardian Name:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

◯Father ◯Stepfather ◯Guardian Name:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

If a parent/guardian's address is different than Responsible Party, Please notify the Front Desk.

Primary Insurance Information

Relationship to Insured: ◯Self ◯Spouse ◯Child ◯Other

Employer:_____

Ins. Company:_____

Ins. Address:_____

If the information requested below is the same as the Responsible Party entered above, mark the circle below and leave blank

◯ Name of Insured:_____

◯ Insured Soc. Sec. #_____

◯ Insured Birth Date:_____

Secondary Insurance Information

Relationship to Insured: O Self O Spouse O Child O Other

Employer:_____

Ins. Company:_____

Ins. Address:_____

If the information requested below is the same as the Responsible Party entered above, mark the circle below and leave blank

◯ Name of Insured:_____

◯ Insured Soc. Sec. #_____

◯ Insured Birth Date:_____

Medical History

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

Have you ever been hospitalized, had a major operation or had a serious head or neck injury? ◯Yes ◯No If yes:_____

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

_____

Do you take or have you taken Phen-fen or Redux? ◯Yes ◯No If yes:_____

Do you take blood thinners? ◯Yes ◯No If yes:_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯Yes ◯No If yes:_____

Are you on a special diet? ◯Yes ◯No **Do you use tobacco?** ◯Yes ◯No

Women: Are you... ◯Pregnant/Trying to get pregnant? ◯Nursing? ◯Taking Oral Contraceptives?

Are you allergic, or have you acted adversely to any of the following?

◯Aspirin ◯Penicillin ◯Codeine ◯Acrylic ◯Metal ◯Latex ◯Sulfa Drugs
◯Local Anesthetics ◯Other? If yes:_____
◯None of the above

Do you use controlled substances? ◯Yes ◯No If yes:_____

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

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

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

_____

Please write in any other pertinent information that has not been covered: _____

_____

Authorization: I hereby authorize the Doctor and/or team member of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears, on these medical and dental histories is correct to the best of my knowledge. I also authorize the doctor and/ or team member to contact my healthcare giver(s) concerning my treatment if necessary.

_____ _____

Patient/Parent/Guardian Signature **Date**