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: ○ 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:_____

Medical History

Please List All Medications you are taking:

_____ _____

_____ _____

_____ _____

_____ _____

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

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

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

○ Aspirin/NSAIDs ○ Codeine ○ Penicillin ○ Antibiotics ○ Metal ○ Local Anesthetics ○ Sulfa Drugs

○ Other? If yes:_____ ○ None of the above

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

Adrenal Insufficiency		Cardiovascular Problems		Dental Anxiety		Mental/Psychiatric Care	
		Angina/Chest Pain				Alzheimer's Disease	
Anaphylaxis		Arrhythmia		Diabetes		Depression	
		Aspirin Therapy		Well - controlled		Psychotic Medication	
Anemia		Coumadin/Warfarin		Poorly - controlled		Severe Anxiety	
		Other Blood Thinner					
Autism/Asperger's		Heart Attack Over 6 months ago		GI Problems		Musculoskeletal	
		Recent Heart Attack		Acid Reflux		Arthritis	
Bleeding Disorder		Heart Failure		Liver Disease		Bone Cancer	
		High Blood Pressure				Bisphosphonates	
Breathing Problems		Well- Controlled		Infectious Disease		Joint Replacement	
Asthma		Poorly- controlled		Genital Herpes		Osteoporosis	
Cigarette Use		Pacemaker		Hepatitis B or C			
COPD/emphysema		Stroke Over 6 months		HIV/ AIDS		Organ Transplant	
Sleep Apnea		Stroke within 6 months		HPV		Currently Pregnant	
Tuberculosis				Syphilis		Recent Major Surgery	
		Premed Antibiotic Prescribed by Physician		Other STD		Seizures/Epilepsy	
Cancer		Congenital Heart Defect requiring premed				Smokeless Tobacco	
Chemotherapy		Infective Endocarditis		Kidney Disease		Substance Abuse	
Head/Neck Radiation		Prosthetic Valve		Dialysis		Thyroid Problems	
		Valvulopathy				NONE OF THE ABOVE	

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.

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. A flat fee of $200.00 will be assessed if my account becomes delinquent. I authorize the doctor or insurance company to release any information required for this claim. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Patient/Parent/Guardian Signature **Date**