

Patient Registration and Health History

Patient Name: _____ Last _____ First _____ Date: _____
 Male Female Married Single Child Other _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ (Cell Phone): _____
 Address: _____
 Street _____ Apartment # _____
 City _____ State _____ Zip Code _____

Health Information

Date of Last Dental Visit: _____ Referred By: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pregnancy
Due date: _____ | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis Type: A B C | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Neck or Back Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | Do you require Pre-Medication before dental appointments? |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Yes _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Tumors | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | | |

- Do you smoke or use tobacco products? How much _____
- Have you ever taken any bisphosphonate medication (Boniva, Aredia, Zometa, Fosamax, Actonel, Didranel, Skelid) for osteoporosis, bone disease, or cancer?

• Phen-fen/Redux Yes No

• **Are you taking any medication, if so, please list:** _____

• Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
 If yes, please explain: _____

• Are you now under the care of a physician? Yes No
 If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• **Do you have any health problems that need further clarification?** Yes No
 If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

 Signature of patient, parent or guardian Date: _____

Tell Us About Yourself...

What do you like about your smile? _____
 What do you see that needs to be changed? _____
 What do you hope to accomplish by seeing a Prosthodontist? _____
 Do you have a budget we need to be aware of? _____
 What will your life be like when the procedure is complete? _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

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

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____

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

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. Please Initial _____.

I give Dr. Yen permission to show my photos of my smile face for education purposes-he can use the photos as he sees fit. Please Initial _____.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____