PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: ❑ M ❑ F Age _____ Birthdate _____ Driver's License # _____ ❑ Single ❑ Married ❑ Divorced

Email: _____ Patient Employed by _____ Patient Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____ Business Phone _____

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

Patient Social Security # _____ Spouse/Parent Social Security # _____

Dental Insurance Company 1) _____ 2) _____ Group #s _____

In Case of Emergency, Contact _____ Phone _____

Whom may we thank for referring you? _____

DENTAL HISTORY

Previous Dentist (if applicable) _____ City _____

Date of last cleaning _____ Date of last dental visit _____ Why? _____

Have you had dental x-rays taken during the past three years? ❑ Yes ❑ No If so, what kind:

❑ Bitewings (one or two on each side to detect cavities) Date _____

❑ Complete Series (16 x-rays) Date _____

❑ Panorex (sitting or standing and machine moves around head) Date _____

Is there any condition in your mouth that is causing you pain or discomfort? ❑ Yes ❑ No If Yes, explain: _____

Do you do any of the following? (check all that apply)

❑ Bite cheeks or lips ❑ Suck fingers ❑ Breathe through mouth ❑ Drink tea/coffee

❑ Bite tongue ❑ Bite fingernails ❑ Tongue thrust ❑ Chew tobacco

❑ Clench teeth ❑ Suck thumb ❑ Notice bad breath frequently ❑ Smoke (cig/pipe)

Are you satisfied with the appearance of your teeth? ❑ Yes ❑ No

What can we do for you today? _____

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 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 have made in the completion of this form.

Date _____ Signature _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Highland Family Dentistry, P.L.L.C's dentists, 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. I further authorize the release of any of Highland's treatment records or x-rays, to other dentists or specialists, to aid in diagnosis or treatment.

_____ _____
Date Signature of Insured/Guardian

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental staff
Name of minor/child

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

By signing below I acknowledge the following: (1) I am responsible for any and all payments or co-payments for services rendered; (2) Any claims submitted to insurance, which are subsequently declined shall become my responsibility; (3) In the event my owed balance should become delinquent, I acknowledge I may additionally become responsible for additional fees including but not limited to: late fees, collection fees, interest, court costs, and attorney fees.

_____ _____
Date Signature of Insured/Guardian