PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Cell Phone ______________________

Date ______________________ Home Phone ______________________

E-Mail Address ______________________________________

Patient ____
Last Name First Name Initial Preferred Name

Street Address ______________________ City ______________________ State ________ Zip __________

Sex: ❑ M ❑ F Age____ Birthdate__________ Driver's License#____________________ ❑ Single ❑ Married ❑ Divorced

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?____

MEDICAL HISTORY

Physician's Name ______________________________ Date of Last Physical ______________

Have you ever had any of the following? (check all that apply)

❑ Heart Problems
❑ High Blood Pressure
❑ Low Blood Pressure
❑ Circulatory Problems
❑ Nervous Problems
❑ Radiation Treatment
❑ Artificial Heart Valves or Joints
❑ Recent Weight Loss
❑ Back Problems
❑ Diabetes
❑ Latex Allergy
❑ Eye Surgery
❑ Respiratory Disease
❑ Epilepsy
❑ Headaches
❑ Hepatitis, Jaundice or Liver Disease
❑ Cancer
❑ Psychiatric Care
❑ Chronic Diarrhea
❑ Allergies to Anesthetics
❑ Allergies to Medicines or Drugs
❑ General Allergies
❑ Blood Disease
❑ Arthritis
❑ Special Diet
❑ Swollen Neck Glands
❑ Taking Bisphosphonate Drugs
❑ Sinus Problems
❑ A.I.D.S. or Other Immunosuppressive Disorders
❑ Stroke
❑ Ulcer
❑ Venereal Disease
❑ Chemical Dependency
❑ Hemophilia
❑ Taking Natural Supplements

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 currently 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?______________________________________

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(over please)

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, what kind: __________

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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? ____

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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 Sunrise's Providers, 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.

______________ ______________________________
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