ROMAS FAMILY DENTAL

PATIENT REGISTRATION FORM

GENERAL INFORMATION

Date _____ Social Security Number _____-___-_____

Patient Name _____
Last Name First Name Preferred Name

Address _____
Number Street Apt. # (If applicable)

City _____ State _____ Zip Code _____

Home Phone # (____)_____ Work Phone # (____)_____ Cell Phone # (____)_____

E-mail (optional) _____

Gender M _____ F _____ Birthday ___/___/_____ Age _____

Marital Status Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Occupation _____

Patient Employer/School _____

Spouse's Name (if applicable) _____

Whom may we thank for referring you? _____

Name of Responsible Party? _____ Relationship to Patient? _____

Responsible Party Date of Birth? _____ Responsible Party SSN? _____

DENTAL INSURANCE

Primary Insurance Company _____ Primary Insurance Phone Number_____

Group Number _____Primary Insurance address_____

Primary Insurance Holder's Name _____ Employer_____

Primary Insurance Holder's Birthday ___/___/_____ Primary Insurance Holder's SSN _____-___-_____

Relationship to Patient _____

Is patient covered by additional Dental insurance? Y _____ N _____

Secondary Insurance Company _____ Secondary Insurance Phone Number_____

Secondary Insurance Group Number _____

Secondary Insurance Holder's Birthday ___/___/_____ Primary Insurance Holder's SSN _____-___-_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company) and assign directly to Dr. Romas all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Representative Please Print Name

_____ _____
Date Relationship to the Patient and

EMERGENCY INFORMATION

In case of an emergency, contact:

1. Name _____ Relationship _____ Phone # (____)_____
2. Name _____ Relationship _____ Phone # (____)_____
3. Name _____ Relationship _____ Phone # (____)_____

Romas Family Dental

Medical History

Physician's Name _____ Date of last visit _____

Physician's Number _____ Under a Physician's care now_____

Have you ever been hospitalized or had a major operation? Y_____N_____ If yes, please explain_____

Have you ever had a serious head or neck injury? Y_____N_____ If yes, please explain_____

Place an x in the box to indicate if you have or have had:

- ☐ AIDS/HIV
- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Bones/Joints
- ☐ Artificial Heart/Valves
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Circulatory Problems
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorders
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type ____
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on neck/head
- ☐ Ulcer
- ☐ Weight Loss, unexplained

FEMALES:
Are you pregnant/Trying to get pregnant? _____ Due Date _____

Are you nursing? _____ Taking birth control pills? _____

Medications

List any medications you are currently taking and and the correlating diagnosis:

_____
_____
_____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: _____

Pharmacy Name: _____
Phone # (____) _____

Do you take, or have you taken, Phen-Fen or Redux? Y_____ N_____ If yes, please explain_____

Do you use tobacco? Y____ N____

Do you use controlled substances? Y_____ N_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GURARDIAN_____ DATE_____