MANASSAS SMILES

Patient Registration Form

PATIENT INFORMATION

First Name		Middle Initial		Last Name			
Nickname		Gender	☐ Male ☐ Female	Birth Date		Age	
Social Security #		Driver's License #		E-mail			
Address		City		State		ZIP Code	
Home Phone		Cell Phone					
Marital Status	☐ Married	☐ Divorced	☐ Legally Separated	☐ Widow	☐ Single		
Employer		Occupation		Business Telephone			

WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE?

☐ Current Patient ☐ Referring Doctor ☐ Internet ☐ Insurance ☐ Other: _____

Referral Name	

EMERGENCY CONTACT

First Name		Last Name	
Relationship to Patient		Telephone #	

RESPONSIBLE PARTY (if self is selected, please skip to the next section)

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other: _____

First Name		Last Name		Social Security #			
Birth Date		Age		Telephone			
Address		City		State		ZIP Code	
Employer		Business Telephone					

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY

Primary Policy Holder	First		Last		
Relation		Gender	☐ Male ☐ Female		
S.S. #		Birth Date			
Address					
City		State		ZIP Code	
Telephone					
Primary Policy Holder Employer					
Business Address					
City		State		ZIP Code	
Business Telephone					
Insurance Co. Name					
Address					
City		State		ZIP Code	
Telephone					
Policy I.D. #					
Group #		Plan Name			

SECONDARY DENTAL INSURANCE COMPANY

Primary Policy Holder	First		Last		
Relation		Gender	☐ Male ☐ Female		
S.S. #		Birth Date			
Address					
City		State		ZIP Code	
Telephone					
Primary Policy Holder Employer					
Business Address					
City		State		ZIP Code	
Business Telephone					
Insurance Co. Name					
Address					
City		State		ZIP Code	
Telephone					
Policy I.D. #					
Group #		Plan Name			

MANASSAS SMILES

Patient Registration Form

HEALTH HISTORY

Height		Weight			
Are you under the care of a physician? If yes, please complete the line below.					☐ Yes ☐ No
Date of Last Visit		Physician Name		Physician Phone	
Preferred Pharmacy		Pharmacy Location		Pharmacy Phone	
Do you smoke or use tobacco?					☐ Yes ☐ No

FOR WOMEN ONLY

Are you pregnant?	☐ Yes ☐ No	If yes, number of weeks	
Are you nursing?	☐ Yes ☐ No	Are you taking birth control pills?	☐ Yes ☐ No

WARNING: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.

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

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding			Frequent Cough			Pacemaker		
AIDS/HIV			Frequent Headaches			Psychiatric Care		
Alcohol Abuse			Glaucoma			Radiation Therapy		
Anemia			Heart Attack/Failure			Respiratory Problems		
Arthritis			Heart Disease			Rheumatic Fever		
Artificial Heart Valve			Heart Murmur			Rheumatism		
Artificial Joints			Heart Surgery			Seizures		
Asthma			Hemophilia			Shingles		
Blood Disease			Hepatitis A			Sickle Cell Disease		
Blood Transfusion			Hepatitis B			Sinus Problems		
Cancer			Hepatitis C			Sleep Apnea		
Chemotherapy			High Blood Pressure			Stomach/Intestinal Problems		
Chest Pains			Irregular Heartbeat			Stroke		
Cold Sores/Fever Blisters			Jaundice			Thyroid Problems		
Congenital Heart Defect			Jaw Joint Pain			Tuberculosis		
Diabetes			Kidney Problems			Tumors/Growths		
Drug Abuse			Liver Disease			Ulcers		
Emphysema			Low Blood Pressure			Venereal Disease		
Epilepsy			Mitral Valve Prolapse					
Fainting Spells/Dizziness			Osteoporosis					

Is there any disease, condition, or problem that you think our office should know about that is not listed above? If yes, please list below.	☐ Yes ☐ No

MANASSAS SMILES

Patient Registration Form

MEDICATIONS

Please list all medications, over the counter and herbal supplements, that you are currently taking (include medication name, dosage and frequency):

ALLERGIES/REACTIONS

Are you allergic to, or had a reaction to any of the following?

	Yes	No		Yes	No
Aspirin			**Codeine**		
Dental Anesthetics			**Erythromycin**		
Jewelry			**Latex**		
Metals			**Penicillin**		
Sulfa Drugs			**Tetracycline**		

Please list any allergy/reaction that you have or have had that is not listed above.

ADDITIONAL NOTES/COMMENTS:

FINANCIAL POLICY

If you do not have dental insurance:

- Payment is due at the time of service.

If you do have dental insurance:

- We will accept benefits for the amount covered by the insurance company. The part not covered by the insurance company is to be paid at the end of each appointment.

Cancellation Policy:

- I understand that if I cancel any dental appointment without giving 48 hours advance notice on a business day, I will be subject to paying a $60 per hour cancellation fee.

FORM COMPLETION

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be 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 Guardian:		**Date:**	

IF PATIENT IS A MINOR

Form signed by:		**Relationship to Patient:**	