

# Patient Registration Form

## Personal Information

Patient \_\_\_\_\_  
First Name Initial Last Name

Are you happy with your smile? Yes No

What would you change? \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_ Birthday \_\_\_\_\_

Sex: M F Marital Status: S M W Sep D Social Security \_\_\_\_\_

Full time student Yes \_\_\_\_\_ NO \_\_\_\_\_ Where \_\_\_\_\_

## Responsible Party

First Name Initial Last Name

## Emergency Contact

Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone number \_\_\_\_\_ Alternate Phone number \_\_\_\_\_

## Insurance Information (If you do not know the following information please contact your insurance company by phone or internet.)

Subscribers Name \_\_\_\_\_ Social Security \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

## Secondary Insurance Information

Subscribers Name \_\_\_\_\_ Social Security \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

## Referral source

How did you hear about us? \_\_\_\_\_

## Assignment and Release

- I certify that I, and/or my dependent(s), have insurance coverage with the above company and assign directly to Dr. Michael Bailey all insurance benefits, if any, otherwise payable to me for services rendered.
- Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. **Your portion of the bill will be due at time of service.**
- If your insurance has not paid within 60 days from the date from the date of service, we will look to you for prompt payment of the account. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party.
- I understand that the cancellation of appointments without 48 hours notice will be subject to a \$75 fee.
- I understand that posterior restorations may be paid at an alternate benefit, and I will be responsible for the difference.
- I understand that, due to any false information, I will be subject to criminal prosecution.

\_\_\_\_\_  
Signature of patient or Responsible party of minor

\_\_\_\_\_  
Date

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**Dental/Medical History**

Are you having pain or discomfort at this time?	Y	N
Do you feel very nervous about having dental treatment?	Y	N
Have you ever had a bad experience in a dental office?	Y	N
Have you been a patient in the hospital during the past two years?	Y	N
Have you been under the care of a medical doctor during the past two years?	Y	N
Have you had any excessive bleeding requiring special treatment?	Y	N
Do you take or have you taken Bisphosphonates? (Didronel, Skelid, Fesamax, Actonel, Boniva, Aredia, Zometa)	Y	N
Have you had any Radiation Therapy for Pituitary or Thyroid disease?	Y	N
<b>When was your last dental cleaning and exam?</b>		

**Women:**

<b>Are you pregnant now?</b>	Y	N
Are you taking birth control pills?	Y	N
Do you anticipate becoming pregnant	Y	N

**Medications**

**Allergies**

List any medications you are currently taking and the corresponding diagnosis:	List any Allergies to medications you have:
	List any Surgeries you have had:
Pharmacy Name:	
Pharmacy Phone:	

**Circle any of the following, which you have had or have at present:**

- |                          |                          |                            |                          |
|--------------------------|--------------------------|----------------------------|--------------------------|
| Heart Failure            | Anemia                   | Diabetes                   | Hepatitis C              |
| Heart Disease or Attack  | Stroke                   | Cortisone Medicine         | Blood Transfusion        |
| Angina Pectoris          | Kidney Trouble           | Glaucoma                   | Drug Addiction           |
| High Blood Pressure      | Ulcers                   | Chemotherapy               | Hemophilia               |
| Low Blood Pressure       | Bruise Easily            | AIDS Related complex (ARC) | Cold Sores               |
| Heart Murmur             | Pain in Jaw Joints       | AIDS/HIV                   | Epilepsy or Seizures     |
| Congenital Heart Lesions | Tuberculosis (TB)        | Hepatitis A (infectious)   | Fainting or Dizzy Spells |
| Heart Pacemaker          | Sinus Trouble            | Hepatitis B (sarum)        | Nervousness              |
| Heart Surgery            | Congenital Defects/Valve | Sickle Cell Disease        | Psychiatric Treatment    |
| Artificial Joints        |                          |                            |                          |
| Mitral Valve Prolapse    |                          |                            |                          |

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?	Y	N
Do your ankles swell during the day?	Y	N
Do you use more than 2 pillows to sleep?	Y	N
Have you lost or gained more than 10 pounds in the past year?	Y	N
Do you ever wake up from sleep short of breath?	Y	N
Are you on a special diet?	Y	N
Has your medical doctor ever said you have cancer or a tumor?	Y	N
Do you have any disease, conditions, or problems not listed? If yes, please list:	Y	N
Have you ever had tonsillectomy (tonsils taken out?)	Y	N

**Please circle any of the following childhood diseases you have had?**

- |               |             |            |                |
|---------------|-------------|------------|----------------|
| Measles       | Chicken Pox | Mumps      | Whooping Cough |
| Scarlet Fever | Scarletina  | Diphtheria | Tonsillitis    |

**Do you use any of the following products? (Please circle)**

- |                 |         |        |
|-----------------|---------|--------|
| Cigarettes      | Alcohol | Cigars |
| Chewing Tobacco | Pipe    | Snuff  |

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Michael L. Bailey, D.D.S.

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have read and understand this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)