GET ACQUAINTED QUESTIONNAIRE Please Fill Out Completely

PATIENT REGISTRATION

Patient Information:	Medical Alert		
Preferred Name	HEALTH QUESTIONS		
Full Name		YES	NO
Street Address	Is your general health good?		
City State Zip Code	Are you under a Physician's care now?		
Home Phone ()	Have you ever had:		
Cell Phone ()E-mail Address	Heart Trouble		
Employer's Name & Address	Heart Murmur Rheumatic Fever		
SS #	Hepatitis	-	
Birthdate Age Sex M[] F[] Marital Status	Asthma	-	
How did you hear about our practice?	Abnormal Bleeding From Extraction		
Purpose for todays visit?	Sinus Trouble		
	Anemia		
~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	High or Low Blood Pressure	_	
Who will be responsible for this account? [] Self [] Spouse [] Parent (If you checked "Self" please skip next section and continue with insurance	Cyst, Growth or Tumor		
information)	Venereal Disease HIV Positive	and the same of	
Person Responsible for this account, other than above patient:	Are you pregnant?		
NameBirthdate	0 (a) (a) (b) (a) (b) (a) (a) (a) (a) (a) (a) (a) (a) (a) (a		17 min
Street Address	Are you now taking any medication?		
City State Zip Code	Is there any other information about your health which should be known?		
Home Phone ()Work Phone ()x		_	
Occupation	Do you have Allergies to: Penicillin		
Employer's Name & Address	Codeine		
SS #	Local Anesthetic (Novocaine)		
Relationship to Patient	Other Drugs		
	M.D.'s Name Phone		
Equation to covered by Dontal Ingurance	Date of Last MEDICAL Exam		
For patients covered by Dental Insurance:	Date of Last Complete DENTAL Exam		
Subscriber's NameBirthdate	Annet sentate state of Annet surgest than 22.	YES	NO
Employer's Name & Address	X-Rays		
SS #	OFFICE POLICY		
Insurance Company Group Number			
Relationship to Patient [] Self [] Spouse [] Parent or Guardian	Payment for Service is expected unless other arran made.	ngeme	nts are
Is the patient covered by another dental insurance?	Although we will gladly fill out your insurance	e form	ns. our
If Yes, please fill out next section.	professional services are rendered and charged to Y the insurance company.		
	I authorize release of any information relating t	to the	dental
Secondary Dental Insurance:	services received here.		
Subscriber's Name Birthdate	Control of the contro		
Employer's Name & Address	Signed (Patient, or Parent if Minor) I hereby direct benefits payable to the attending denti		
SS #			
Insurance Company Group Number			
Relationship to Patient [] Self [] Spouse [] Parent or Guardian	Signed (Patient, or Parent if Minor) Date	e	