DENTAL REGISTRATION
PERSONAL DATA

Patient Name ____
Last First Middle

Address ____
Number and Street

City, State, Zip ____

Billing Address ____
Number and Street

Billing Address ____
City State Zip

Home Telephone ______________________ Work Telephone ______________________

Birthdate ______________________ Driver Lic. No. ______________________

FINANCIAL DATA

Holder of Insurance ____

Social Security Number ____/____/____ Sex M F Driver Lic. No. ______________________

Insurance Co. Name ____

Group No. ______________ Local No. ______________ Policy No. ______________

Employer Name & Address ____

Nearest Relative Name ____
Relationship

____
Address City State Zip Telephone

Physicians Name ____

____
Address City State Zip Telephone

Chief Complaint ____

Referred By ____
Address City/State/Zip

DEPENDENTS

______________________ ______________________
Name First & Last (if different) Name First & Last (if different)

______________________ ______________________
Name First & Last (if different) Name First & Last (if different)

MEDICAL — DENTAL HISTORY

PATIENT NAME ______________________ AGE __________ DATE __________

CHECK YES OR NO

PATIENT MEDICAL HISTORY

- ☐ YES ☐ NO Are you under any Medical treatment now?
- ☐ YES ☐ NO Have you had any major operations? If so, what? __________
- ☐ YES ☐ NO Have you ever had a serious accident involving head or jaw injuries?
- ☐ YES ☐ NO Have you had any adverse response to any drugs including penicillin and aspirin?
- ☐ YES ☐ NO Have you ever had any of the following?

☐ Heart Ailment	☐ Any Blood Disease
☐ High Blood Pressure	☐ Any Liver Disease
☐ Low Blood Pressure	☐ Any Kidney Disease
☐ Respiratory Disease	☐ Any Stomach or Intestinal Disease
☐ Diabetes	☐ Any Venereal Disease
☐ Rheumatic Fever	☐ Yellow Jaundice or Hepatitis
☐ Rheumatism or Arthritis	☐ Epilepsy
☐ Tumors or Growths	☐ HIV or ARC

- ☐ YES ☐ NO Are you on a diet at this time?
- ☐ YES ☐ NO Are you now taking drugs or medications?
- ☐ YES ☐ NO Are you allergic to any known materials resulting in - hives, asthma, eczema, etc?
- ☐ YES ☐ NO Are you in general good health at this time?
- ☐ YES ☐ NO Have any wounds healed slowly or presented other complications?
- ☐ YES ☐ NO Are you pregnant?
- ☐ YES ☐ NO Do you have a history of fainting?
- ☐ YES ☐ NO Have you ever had any X-RAY TREATMENTS (other than diagnostic)?

PATIENT DENTAL HISTORY

- ☐ YES ☐ NO Do you have any specific problems?
- ☐ YES ☐ NO Do you have pain in or near your ears?
- ☐ YES ☐ NO Do you have any unhealed injuries or inflamed areas in or around your mouth?
- ☐ YES ☐ NO Have you experienced any growth or sore spots in your mouth?
- ☐ YES ☐ NO Does any part of your mouth hurt when clenched?
- ☐ YES ☐ NO Have you ever had Novocaine anesthetic?
- ☐ YES ☐ NO Any reactions or allergic symptoms to novocaine?
- ☐ YES ☐ NO Any difficult extractions in the past?
- ☐ YES ☐ NO Have you had prolonged bleeding following extractions in the past?
- ☐ YES ☐ NO Do your gums bleed?
- ☐ YES ☐ NO Have you ever been instructed on the correct method of brushing your teeth?
- ☐ YES ☐ NO Have you ever been instructed on the care of your gums?
- ☐ YES ☐ NO Do you chew on only one side of your mouth?
- ☐ YES ☐ NO Do you habitually clench your teeth during the night or day?
- ☐ YES ☐ NO When was your last full mouth X-RAY taken? __________ Where? __________
- ☐ YES ☐ NO Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)? If so, locate __________

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature ______________________

Date __________

RECERTIFICATION: I certify that there have been no changes in my health except as noted below.

Date	Change	Signature

CURRENT MEDICATION	REASON

MEDICAL / DENTAL HISTORY

PATIENT'S NAME ______________________

HENRY D. MOORE, D. D. S.
DENTAL CONCEPTS
1111 EAST 87TH STREET
CHICAGO , ILLINIOS 60619
Telephone (312) 374- 9778

FINANCIAL AGREEMENT

The charges for all dental treatment / services rendered by Dr. Moore are the responsibility of the patient (adult) or parent (if a child) and the parent who presents the child for treatment.

As a courtesy to our patients , we will complete and file your insurance forms relative to service rendered .We are obliging our patients by agreeing to wait sixty (60) days to receive payment from your insurance company, you (the patient) are responsible for payment for service. Any dispute, disagreement, or misunderstanding, must be dealt with you and the insurance company, not Dr. Moore, cannot and will not be an excuse or alibi for non-payment by you.

When determining your co-payment, we can only estimate what your insurance company will pay. It is your responsibility to know what your benefits are. Dr. Moore is not privy to that information for each and every insurance company. All balances remaining upon payment (or partial payment) by your insurance company are your total responsibility.

In the event of default or lack of payment, all costs associated with the collection of your debt, including legal costs, collections agency, attorney costs, court costs, personal costs, and interest shall be added to your balance and payable by you.

When you cancel or miss a scheduled appointment and do not give us the courtesy of a 48 hours advance notice, you will be charged a fee of $50.00 for each hour or portion thereof that you were scheduled.

Past due balances are subject to a finance charge of 1% per month or 12% annually.
I have read, and understand the above policy, I have been given a copy of the office financial policy, and I agree to pay for all service rendered and not paid by insurance company.

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Signature of Patient/parent/Responsible Party Date

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Witness Date