PATIENT REGISTRATION

Please complete the following confidential information and sign both front & back.

EASTRIDGE DENTAL ASSOCIATES

Patient Information

Date _____

Patient's Legal Name last _____ first _____ m.i. _____

By what name do you wish to be called? _____

Residence street _____ city _____ state _____ zip _____

Home Phone _____ Birthdate _____ Social Security # _____

Children _____

If patient is a minor, give parent's or guardian's name _____

Is another member of your family or relative a patient at our office? name _____ relation _____

How did you hear of our office _____

Responsible Party Information

Name last _____ first _____ m.i. _____ Single ___ Married ___ Divorced ___ Widowed ___

Residence street _____ city _____ state _____ zip _____

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) street _____ city _____ state _____ zip _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ Date Employed _____

Spouse's Name last _____ first _____ m.i. _____ Relationship to Patient _____

Employer _____ Occupation _____ Date Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Dental Insurance Company

Address street _____ city _____ state _____ zip _____

Employee Name _____ Date of Birth _____

Employee Social Security # _____ Relationship to Patient _____

Employer _____ Group Number _____

Secondary Insurance Company

Address street _____ city _____ state _____ zip _____

Employee Name _____ Date of Birth _____

Employee Social Security # _____ Relationship to Patient _____

Employer _____ Group Number _____

I, the undersigned (patient or legally responsible party) authorize treatment to be rendered by the dentist and is staff, and assume full financial responsibility, I authorize the release of any information necessary for the filing of insurance claims and hereby authorize payment directly to the dentist for benefits payable to me by the insurance company or administrator. I understand where appropriate, credit bureau reports may be obtained. This is valid until written notification from me.

Signature _____ Date _____

Dental History

What is the reason for your visit today?_____

Date of....Last Dental Visit? _____ Last Dental Cleaning? _____

Last Full Mouth X-rays?_____Previous Dentist's name _____

Do you have any dental problems now? _____

Have you ever had.....please circle all that apply

Periodontal Treatment	Mouth odors or bad tastes	Dizziness
Oral Surgery	Sores or lesions	Ear pain
Orthodontic Treatment	Bleeding gums	Jaw pain
Injury to the mouth or head	Sensitive teeth	Neck pain
Jaw joint noises, clicking	TMJ Treatment	Snoring

Are you satisfied with your teeth's appearance? _____

Have you ever had an upsetting dental experience? _____

Are you interested in any specific dental treatment? Cosmetic? _____ Orthodontic? _____

Other? _____

Health History

Physician's Name _____ Date of your last visit _____

Are you under care now?_____For what reason? _____

Have you had any illnesses, operations, or accidents? _____

Have you been hospitalized for any reason? _____

Have you ever had any of the following?.....please circle all that apply

Heart disease/surgery	Psychiatric Treatment	Chemical dependency	Hepatitis
Congenital Heart Problem	Kidney trouble	Stroke	Epileptic seizures
Heart Murmur	Stomach ulcers	Anemia	Headaches
High Blood Pressure	Venereal disease	Fainting	Food Allergys
Low Blood Pressure	Diabetes	Jaundice	Tuberculosis
Rheumatic fever	Asthma	Cancer	Sinus/Ear Problems
HIV or Aids	Emphysema	Radiation Therapy	Artificial Joints
Latex Sensitivity	Glaucoma		

Are you allergic to penicillin?_____ or anything else? _____

Have you had any adverse reaction to any drug or medication? _____

Are you taking any aspirin?_____vitamins?_____ Birth control pills?_____

Are you taking any medications, prescription or non-prescription? _____

Please list them and the reasons you are taking them _____

_____

_____

Have you had any excessive bleeding with minor cuts, surgery, or extractions? _____

Explain?_____

Are you pregnant? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____