NELSON BURY DENTISTRY

PATIENT REGISTRATION *NP PW & CONSENTS*

First Name:_____ **Last Name:**_____ **Middle Initial:**_____

Preferred Name:_____ **Patient Is:** **O** Responsible Party **O** Policy Holder

Patient Information

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Birth Date:_____ Email:_____

If patient is the Responsible Party: Driver's License #:_____ Soc. Sec. #:_____

Your Employer:_____ Your Occupation:_____

Employment Status: O Full Time O Part Time O Retired Student Status: O Full Time O Part Time O N/A

Emergency Contact Name & Phone #:_____

Preferred Pharmacy & Location:_____

Primary Care Physician Name & Phone #:_____

How did you hear about us? **O** Google/Facebook **O** Specialist Referral **O** Family/Friend:_____ **O** Other

Responsible Party – Account/Payment (If someone other than patient)

Relationship to patient: **O** Spouse **O** Mother **O** Father **O** Guardian **O** Other:_____

Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

Birth Date:_____ Soc. Sec. #:_____ Drivers License #:_____

For children 18 years and younger – Parent Information (If any other than Responsible Party)

O Mother **O** Stepmother **O** Guardian Name:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

O Father **O** Stepfather **O** Guardian Name:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

If a parent/guardian's address is different than Responsible Party, Please notify the Front Desk.

Primary Insurance Information

Relationship to Insured: O Self O Spouse O Child O Other

Employer:_____

Ins. Company:_____

Ins. Address:_____

If the information requested below is the same as the Responsible Party entered above, mark the circle below and leave blank

O Name of Insured:_____

O Insured Soc. Sec. #_____

O Insured Birth Date:_____

Secondary Insurance Information

Relationship to Insured: O Self O Spouse O Child O Other

Employer:_____

Ins. Company:_____

Ins. Address:_____

If the information requested below is the same as the Responsible Party entered above, mark the circle below and leave blank

O Name of Insured:_____

O Insured Soc. Sec. #_____

O Insured Birth Date:_____

Please List All Medications you are taking:

_____ _____

_____ _____

_____ _____

_____ _____

Do you have a preferred pharmacy? **O** Yes **O** No If yes:_____

Are you under a physician's care now? **O** Yes **O** No If yes:_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? **O** Yes **O** No If yes:_____

Are you allergic, or have you acted adversely to any of the following?

O Aspirin/NSAIDs O Codeine **O** Penicillin **O** Antibiotics **O** Metal **O** Local Anesthetics **O** Sulfa Drugs

O Other? If yes:_____ **O** None of the above

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

Adrenal Insufficiency	Y	N
Anaphylaxis	Y	N
Anemia	Y	N
Autism/Asperger's	Y	N
Bleeding Disorder	Y	N
Breathing Problems	Y	N
Asthma	Y	N
Cigarette Use	Y	N
COPD/emphysema	Y	N
Sleep Apnea	Y	N
Tuberculosis	Y	N
Cancer	Y	N
Chemotherapy	Y	N
Head/Neck Radiation	Y	N

Cardiovascular Problems	Y	N
Angina/Chest Pain	Y	N
Arrhythmia	Y	N
Aspirin Therapy	Y	N
Coumadin/Warfarin	Y	N
Other Blood Thinner	Y	N
Heart Attack Over 6 months ago	Y	N
Recent Heart Attack	Y	N
Heart Failure	Y	N
High Blood Pressure	Y	N
Well- Controlled	Y	N
Poorly- controlled	Y	N
Pacemaker	Y	N
Stroke Over 6 months	Y	N
Stroke within 6 months	Y	N

Premed Antibiotic Prescribed by Physician	Y	N
Congenital Heart Defect requiring premed	Y	N
Infective Endocarditis	Y	N
Prosthetic Valve	Y	N
Valvulopathy	Y	N

Dental Anxiety	Y	N
Diabetes	Y	N
Well - controlled	Y	N
Poorly - controlled	Y	N
GI Problems	Y	N
Acid Reflux	Y	N
Liver Disease	Y	N
Infectious Disease	Y	N
Genital Herpes	Y	N
Hepatitis B or C	Y	N
HIV/ AIDS	Y	N
HPV	Y	N
Syphilis	Y	N
Other STD	Y	N
Kidney Disease	Y	N
Dialysis	Y	N

Mental/Psychiatric Care	Y	N
Alzheimer's Disease	Y	N
Depression	Y	N
Psychotic Medication	Y	N
Severe Anxiety	Y	N
Musculoskeletal	Y	N
Arthritis	Y	N
Bone Cancer	Y	N
Bisphosphonates	Y	N
Joint Replacement	Y	N
Osteoporosis	Y	N
Organ Transplant	Y	N
Currently Pregnant	Y	N
Recent Major Surgery	Y	N
Seizures/Epilepsy	Y	N
Smokeless Tobacco	Y	N
Substance Abuse	Y	N
Thyroid Problems	Y	N
NONE OF THE ABOVE		

Have you ever had any serious illness not listed? **O** Yes **O** No If yes:_____

Please write in any other pertinent information that has not been covered: _____

_____

Authorization: I hereby authorize the Doctor and/or team member of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears, on these medical and dental histories is correct to the best of my knowledge. I also authorize the doctor and/ or team member to contact my healthcare giver(s) concerning my treatment if necessary.

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. A flat fee of $200.00 will be assessed if my account becomes delinquent. I authorize the doctor or insurance company to release any information required for this claim. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____ _____

Print Patient Name: **Patient/Parent/Guardian Signature** **Date**