

REGISTRATION/ HISTORY

Date _____

Patient's Name _____ Single Married Child

Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Name of Spouse or Parent's Name, if minor _____

Patient Employed by _____ Phone _____

Business Address _____

Present Position _____

Spouse Employed By _____ Phone _____

Business Address _____

In case of an Emergency, who should be notified _____ Phone _____

Who will pay this account _____

Do you have insurance that may cover any part of our professional services..... Yes No

If so, name of primary company _____ Policy No. _____ ID# _____

Social Security # of Policy Holder _____ Date of Birth of Policy Holder _____

Do you have any other insurance..... Yes No

If so, name of secondary company _____ Policy No. _____ ID# _____

Social Security # of Policy Holder _____ Date of Birth of Policy Holder _____

Purpose of this appointment _____

Who may we thank for referring you _____

FINANCIAL RESPONSIBILITY AGREEMENT

In consideration of treatment rendered to the above named patient. I accept full financial responsibility. Insurance forms will be completed as a convenience to the patient; however, payment to the doctor is expected at the time services are rendered, unless other arrangements are made in advance. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection fees, interest of 18% APR, court costs and reasonable attorney fees. I also agree and assign any/all insurance benefits to be paid directly to Dr. P. Bruce Easter, D.D.S., P.C.

Date _____ Signature _____

Date of last Health care examination _____ Current age _____

For what _____

Have you ever been hospitalized in the last 5 years _____ if so, for what _____

Do you have or have you ever had:

	Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ Positive/Aids	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	S ___/D ___/___		
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to:		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Medication or Drugs *if yes please list below	<input type="checkbox"/>	<input type="checkbox"/>
			Women: Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

If allergic to medications or drugs, indicate which ones _____

Are you taking any medication now _____ if so, for what _____

Please list any current medications _____

Other physical conditions we should be aware of _____

Name of your physician _____ Phone _____

Are you receiving care now _____ if so nature of care _____

Previous Dentist _____

Address and Phone, if known _____

May we request your records/x-rays _____

When was your last examination and cleaning _____

How many times a day do you brush _____ How many times a day do you floss _____

What are your primary dental Concerns _____

Are you interested in whitening your teeth _____

On a scale of 1-10 how would you rate your overall oral health (1=poor 10=excellent) _____