PATIENT REGISTRATION

Date_____ **Referred By** _____

PATIENT INFORMATION Name_____ Prefer to be called_____

Mailing Address _____

Email Address _____ Birthdate _____ Age_____

Home Phone #_____ Work Phone #_____ Ext. # _____ Cell # _____

Social Security # _____ Driver's License #_____ Spouse's Name _____

Employer _____ Occupation _____

Emergency Contact Name _____ Phone # _____

RESPONSIBLE PARTY / INSURED (if different from patient)

Name_____Relationship to Patient _____ Birthdate _____Age _____

Mailing Address _____

Home Phone #_____ Work Phone #_____ Ext. # _____

Social Security # _____ Driver's License #_____ Spouse's Name _____

DENTAL INSURANCE INFORMATION (if applicable)

Insured's Name _____Relationship to Patient _____ Insured ID # _____

Ins. Co. Name _____ Policy/Group #_____

Ins. Co. Address/Phone_____

How do you plan to pay for services ... ☐ Check ☐ Cash ☐ Credit Card (Visa/MasterCard/Discover/American Express/Care Credit)

In the following questions, please circle YES or NO. Your answers are for our records and are confidential.

YES NO Are you in good general health?

YES NO Has there been a change in your health in the last year?

My last physical exam was: _____

YES NO Are you now under the care of a physician?

Physician's Name/Phone # _____

YES NO Have you had any serious illness or operation?

YES NO Have you been hospitalized within the last five years?

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

YES NO Damaged heart valve or artificial heart valve

YES NO Congenital heart lesions

YES NO Heart murmur

YES NO Rheumatic fever

YES NO Mitral valve prolapse

YES NO Cardiovascular disease: ☐ heart trouble ☐ heart attack ☐ stroke ☐ coronary insufficiency or occlusion ☐ high blood pressure ☐ low blood pressure

YES NO Have you ever taken "Phen Phen"?

YES NO A pacemaker

YES NO Chest pain with exertion

YES NO Shortness of breath after mild exercise

YES NO Ankles that swell

YES NO Shortness of breath when you lie down or need extra pillows to sleep

YES NO Artificial joint

YES NO Allergy

YES NO Asthma or hay fever

YES NO Hives or skin rash

YES NO Sinus trouble

YES NO Diabetes

YES NO Hepatitis, jaundice or liver disease

YES NO Ulcers

YES NO Kidney trouble

YES NO Tuberculosis

YES NO Persistent cough or cough up blood

YES NO Epilepsy or seizures

YES NO Fainting spells

YES NO Psychiatric problems

YES NO Cancer

YES NO AIDS/HIV infection

YES NO Swollen lymph glands

YES NO Deafness

YES NO Pneumonia

YES NO Abnormal bleeding associated with previous surgery or trauma

YES NO Problems with bruising easily

YES NO Blood transfusion

YES NO Blood disorders, such as anemia

YES NO Surgery or radiation for a tumor in the head or neck

YES NO **Are you taking or have you taken Bisphosphonate/bone drug?**

*Actonel *Aredia *Bonefos *Boniva *Didronel *Fosamax *Fosamax Plus D *Ostac *Pamidronate *Prolia *Reclast *Skelid *Xgeva *Zometa

YES NO Are you taking any drug (include over-the-counter)

Please list: _____

_____

_____

_____

_____

YES NO Have you taken any cortisone or steroid within 2 years?

YES NO Do you have a disease or condition not listed that you think I should know about? Please list below.

_____

_____ **(OVER)**

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

YES NO Are or have you been in a situation which exposes you regularly to x-rays or radiation?
YES NO Do you wear contact lenses?
YES NO Women only: Are you pregnant?
YES NO Women only: Are you nursing?

Are you allergic to or have you reacted adversely to:

YES NO Local anesthetics (novocaine, etc.)
YES NO Penicillin
YES NO Sulfa/Sulfites
YES NO Other antibiotics
YES NO Barbiturates, sedatives or sleeping pills
YES NO Aspirin
YES NO Iodine
YES NO Codeine or other narcotics
YES NO Metals (jewelry, etc.)
YES NO Latex
YES NO Other _____

Do you or have you had?

YES NO Serious trouble with previous dental work
YES NO Abnormal bleeding associated with previous extractions
YES NO Periodontal (gum) surgery or disease
YES NO Wisdom teeth removal
YES NO Cold sores
YES NO Red, white or purple patches in your mouth
YES NO Bleeding or sore gums
YES NO Pain, clicking or locking in your jaw
YES NO Difficulty opening your mouth widely
YES NO Pain or soreness in the muscles of your face or neck

_____

_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold Dr. Butz or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I agree that it is my responsibility to notify Dr. Butz or his staff of any changes in my health, operations, illnesses, new medications, new allergies, etc. which may occur in the future.

Signed _____ Date _____
(by patient / responsible party)

Signed _____ Date _____
(by the dentist)

FINANCIAL POLICY: All professional services are to be paid in full on the date they are rendered. Any questions regarding this should be discussed with the office manager prior to being seen. We are happy to cooperate with those who have dental insurance. We will assist you in completing forms and helping you receive maximum benefits; however, please remember that the patient/responsible party is responsible for all charges, regardless of the insurance coverage! On your first visit we ask that you pay this office in full and have the insurance company reimburse you any amount that may be payable. After the first visit we may, at our discretion, accept payment directly from the insurance company. In order to do this we MUST have your insurance information so we can determine what the estimated insurance payment will be. As we do not bill, you will be asked to pay your deductible and estimated amount as treatment is performed. When the insurance pays and if you have a credit on your account, a check will be issued to you promptly. You will be notified should any balance remain after the insurance has paid fully. This policy has been developed to minimize inconvenience, maximize benefits, and ultimately keep your treatment costs down. Thank you for your cooperation. If you have any questions, please ask us.

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I agree to follow the policy as set forth above and understand that I am solely responsible for any charges incurred. I hereby authorize Dr. Butz and his staff to file any insurance claims for me (if applicable) using my signature below on file. I also authorize the release of any necessary information relating to treatment to my insurance company, or other healthcare provider as stated in our HIPPA Privacy Policy.

Signed _____ Date _____
(by patient / responsible party)