Patient Registration Information

Date_____

Name_____ Patient #_____

WILLIAM HURTT DMD PC

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask–we will be happy to help!

Personal Information

Home address_____ City_____ State_____ Zip_____

Birthdate_____ Home Phone_____ Work Phone_____

E-Mail_____ Cell Phone_____

Do you prefer to receive calls at: ☐Work ☐Home ☐Either

Are you: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Your or your parent/guardian's employer_____

Occupation_____

Business address_____ City_____ State_____ Zip_____

Spouse or parent/guardian's name_____

Employer_____ Work Phone_____

If you are a student, name of school/college_____

City_____ State_____

Whom may we thank for referring you?_____

Person to contact in case of an emergency_____ Phone_____

Responsible Party

Name of person responsible for this account_____ Relationship_____

Address_____ City_____ State_____ Zip_____

SS #/SIN_____ Driver license #_____ Birthdate_____

Financial institution_____

E-Mail_____ Cell Phone_____

Employer_____ Work Phone_____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured_____ Relationship to patient_____

Birthdate_____ SS #/SIN_____ Date employed_____

Employer_____ Work phone_____

Address of employer_____ City_____ State_____ Zip_____

Insurance company_____ Group #_____ Employer/Cert. #_____

Ins. co. address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit?_____

Additional Insurance

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured_____ Relationship to patient_____

Birthdate_____ SS #/SIN_____ Date employed_____

Employer_____ Work phone_____

Address of employer_____ City_____ State_____ Zip_____

Ins. co. address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit?_____

Authorization, Release and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may less pay than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____

SINGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Pay in full at each appointment.

☐ Cash ☐ Personal Check

☐ Credit Card

Card #_____Expiration Date_____

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help you.

WILLIAM HURTT DMD PC

MEDICAL HISTORY

PATIENT NAME_____ Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes, please explain:_____
Have you ever been hospitalized or had a major injury?	○ Yes ○ No	If yes, please explain:_____
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes, please explain:_____
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes, please explain:_____
Do you take, or have you taken Phen-Fen or Redux?	○ Yes ○ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications contain bisphosphonates?	○ Yes ○ No	
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex

☐ Sulfa drugs ☐ Other:_____

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heart Beat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any other serious illness not listed above? ○ Yes ○ No

Do you require antibiotic pre-medication before dental treatment? ○ Yes ○ No

Medications: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE