Gloria E. Ward, DDS, MS, MIS, PC

PATIENT REGISTRATION AND MEDICAL HISTORY FORM

Patient Information

First Name: ____________ Middle Initial: ____________ Last Name: ____________
Address: ____________ Address 2: ____________
City: ____________ State: ____________ ZIP: ____________
Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth date: ____________ SSN: ____________ Drivers License: ____________
Email: ____________ I prefer receiving correspondences via email
Emergency Contact & Relationship: ____________ Phone numbers ____________

Responsible Party (if someone other than patient)

First Name: ____________ Middle Initial: ____________ Last Name: ____________
Address: ____________ Address 2: ____________
City: ____________ State: ____________ ZIP: ____________
Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth date: ____________ SSN: ____________ Drivers License: ____________
Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: ____________ Relationship to Insured: ____________
Insured SSN: ____________ Insured Date of Birth: ____________
Employer: ____________ Insurance Company: ____________
Address: ____________ Address: ____________
Address 2: ____________ Address 2: ____________
City, State, Zip: ____________ City, State, Zip: ____________
Rem. Benefits: ____________ Rem. Deductable: ____________

Secondary Insurance Information

Name of Insured: ____________ Relationship to Insured: ____________
Insured SSN: ____________ Insured Date of Birth: ____________
Employer: ____________ Insurance Company: ____________
Address: ____________ Address: ____________
Address 2: ____________ Address 2: ____________
City, State, Zip: ____________ City, State, Zip: ____________
Rem. Benefits: ____________ Rem. Deductable: ____________

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
Dental Office Yellow Pages Newspaper Internet School Work
Other ____________

Name of person or office referring you to our practice: ____________

Medical History

Are you under a physician's care now? Yes No

If yes, please explain: ______

Name of Physician: ______ Phone: ______

Have you ever been hospitalized or had a major operation? 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, herbal remedies, pills, or drugs? Yes No

If yes, please explain: ______

Do you use tobacco? Yes No   Do you drink alcohol? Yes No

Do you drink grape fruit juice? Yes No

Do you have any allergies? Yes No If yes, please explain: ______

Do you have any of the following? (check all that apply)

AIDS	Head Injuries	Pregnancy
Allergies	Heart Attack	Radiation Treatment
Anemia	Heart Disease	Respiratory Problems
Arthritis	Heart Murmur	Rheumatic Fever
Artificial Joints	Hepatitis	Rheumatism
Asthma	High Blood Pressure	Sinus Problems
Blood Disease	HIV Positive	Sleep Apnea
Cancer	Hospitalization	Snoring
Diabetes	Jaundice	Stomach Problems
Dizziness	Joint replacement	Stroke
Epilepsy	Kidney Disease	Thyroid
Excessive Bleeding	Liver Disease	Tuberculosis
Fainting	Mental Disorders	Tumors
Glaucoma	Multiple Sclerosis	Ulcers
Growths	Nervous Disorders	Venereal Disease
Hay Fever	Pacemaker	OTHER: ______

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 my changes in medical status.

______ ______

Signature of Patient, Parent, or Guardian   Date

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In understand that the fee estimated for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______ ______ ______

Signature of Patient, patient or guardian   Date   Relationship to patient

______ ______ ______

Signature of guarantor of payment/responsible party   Date   Relationship to patient