Jared S. Fox, DDS
Kelly B. Deeter, DDS

Patient Registration

Patient Information

Date: _____ First Name: _____ Last Name: _____
Address: _____ Home Phone: _____
City/State/Zip: _____ Work Phone: _____

Birth Date: _____ SS# _____ Sex: Male ❑ Female ❑
E-Mail _____ Cellular: _____ D.L. # _____

❑ Single
❑ Married
❑ Separated
❑ Divorced
❑ Widowed

Employment Status: Full Time ❑ Part Time ❑ Retired ❑
Employer: _____
Student Status: Full Time ❑ Part Time ❑ School: _____
Who may we thank for referring you? _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Work Phone: _____
Birth Date: _____ SS# _____
Sex: Male ❑ Female ❑
E-Mail _____ Cellular: _____
❑ Would you like us to confirm appointments via e-mail?

Emergency Contact

Name: _____
Relation: _____
Phone #: _____

Closest family member not living with you:
Name: _____
Relation: _____
Phone #: _____

Primary Insurance Information (complete or have ID card available)

Name of Insured: _____ SS# _____ Birth Date _____
Relationship to Patient: Self ❑ Spouse ❑ Parent ❑ Other _____
Employer _____ Ins. Company _____
Address: _____ Address: _____
City/State/Zip _____ City/State/Zip _____

Secondary Insurance Information (complete or have ID card available)

Name of Insured: _____ SS# _____ Birth Date _____
Relationship to Patient: Self ❑ Spouse ❑ Child ❑ Other _____
Employer _____ Ins. Company _____
Address: _____ Address: _____
City/State/Zip _____ City/State/Zip _____

The undersigned hereby authorizes doctor to use appropriate tools for diagnosing and treating dental disease. I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a $5.00 statement charge may be added to my account.

Patient or Responsible Party _____ Relationship to Patient _____

Medical History

Patient Name _____ Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may 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 ❑ Physician's name _____

Have you ever been hospitalized or had a major operation? yes ❑ no ❑

Have you had any joints replaced or surgically placed items (pins, mesh or stints)? yes ❑ no ❑

Have you ever had a serious head or neck injury? yes ❑ no ❑

If yes to any above questions please explain: _____

_____

List current medications: _____

_____

Updated: _____

Updated: _____

Do you use tobacco? yes ❑ no ❑

Women: Are you pregnant or trying to get pregnant? yes ❑ no ❑ Nursing? yes ❑ no ❑

Taking oral contraceptives? yes ❑ no ❑

Comments: _____

_____

Do you have any allergies?

Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Latex ❑ Metal ❑

Local Anesthetics ❑ Other _____

Circle any of the following you have, or have had in the past.

Aids/HIV Positive	Chest Pains	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores/Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack/Failure	Low Blood Pressure	Spina Bifida
Arthritis/Gout	Diabetes	Heart Murmur	Lung Disease	Stomach/Intestinal Disease
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	Mitral Valve Prolapse	Stroke
Artificial Joint	Easily Winded	Heart Trouble/Disease	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiation Treatments	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors or Growths
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives or Rash	Rheumatic Fever	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

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 or Responsible Party _____ Date _____