REGISTRATION FORM

PATIENT INFORMATION

TODAY'S DATE:

Patient's last name:	**First:**	**Middle:**	☐ Dr. ☐ Mrs.	☐ Mr ☐ Ms.	**Marital status (circle one)** ☐ Single / ☐ Mar / ☐ Div / ☐ Sep / ☐ Wid
What name do you prefer to go by?			**Birth date:** / /	**Age:**	**Sex:** ☐ M ☐ F
Street address: **How long at this address?**			**Social Security Number:**	**Drivers license Number:**	
PO Box:	**City:**		**State:**	**ZIP Code:**	
Occupation:	**Employer:**			**Employer phone:** ( )	
Home Phone: ( )	**Cell Phone:** ( )		**Alternate Phone:** ( )		
Email:					
Spouse's Name:	**Spouse's Employer:**		**Spouse's Work Phone:** ( )		
Whom may we thank for referring you to our office?	**Other family members seen here:**				

PAYMENT INFORMATION

Is the person who is responsible for the bill the patient listed above? ❑ **Yes** ❑ **No (please fill in the below information)**

Person Responsible for Bill:	**Birth Date:** / /	**Address:**	**Phone:** ( ) ☐ Mobile ☐ Home ☐ Other	**Is this person a patient here?** ☐ Yes ☐ No
Occupation:	**Employer:**	**Employer Address:**	**Employer Phone:** ( )	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone number:** ( )	**Work phone number:** ( )

PLEASE SIGN & DATE

The financial responsibility of each patient must be determined before treatment. This office depends upon reimbursement from the patient for the costs incurred in their case. I hereby assign all dental benefits which I am entitled, including private insurance & any other dental plan to: Dr. Gerwig at Gerwig Family Dental. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment. I understand that if payments are not made in a timely manner, a 12% finance charge will be my additional responsibility to pay.

Payment is expected at time of service & for your convenience we accept cash, check, MasterCard, Visa, Discover, Citi Health Card, & Care Credit.

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

I hereby certify that the above information is true and correct and acknowledge and accept all obligations as provided hereinabove.

_____ _____

Patient or Parent/Guardian signature Date

Patient Medical-Dental History

Patient:_____ Primary Medical Physician_____ Choose One:

1. Are you under any medical treatment now?_____ 1. ☐ Yes ☐ No
2. Have you had any major operations? If so, what? _____ 2. ☐ Yes ☐ No

   _____
3. Have you had any adverse reactions to any drugs **including** penicillin?
   List:_____ 3. ☐ Yes ☐ No
4. Has a physician ever informed you that you had (Please list conditions in the space provided):
   a. A heart ailment?_____ a. ☐ Yes ☐ No
   b. High blood pressure?_____ b. ☐ Yes ☐ No
   c. Respiratory disease (including asthma)?_____ c. ☐ Yes ☐ No
   d. Diabetes?_____ d. ☐ Yes ☐ No
   e. Rheumatic fever?_____ e. ☐ Yes ☐ No
   f. Tumors or growths?_____ f. ☐ Yes ☐ No
   g. **ANY** blood disease?_____ g. ☐ Yes ☐ No
   h. **ANY** liver disease?_____ h. ☐ Yes ☐ No
   i. Osteoporosis requiring medication?_____ i. ☐ Yes ☐ No
   j. **ANY** stomach or intestinal disease?_____ j. ☐ Yes ☐ No
   k. **ANY** venereal disease?_____ k. ☐ Yes ☐ No
   l. Yellow jaundice or hepatitis?_____ l. ☐ Yes ☐ No
   m. Thyroid deficiency or taking **ANY** thyroid medication?_____ m. ☐ Yes ☐ No
5. Are you now taking drugs or medications? (Please list):_____ 5. ☐ Yes ☐ No

   _____

   _____

   _____
6. Are you in general good health at this time?_____ 6. ☐ Yes ☐ No
7. Have you ever had **ANY** prosthetic implants? (including joint or cosmetic, etc.)_____ 7. ☐ Yes ☐ No
8. Have you ever tested **positive** for HIV or AIDS?_____ 8. ☐ Yes ☐ No
9. Have any wounds healed slowly or presented other complications?_____ 9. ☐ Yes ☐ No
10. Are you pregnant?_____ 10. ☐ Yes ☐ No
11. Do you have a history of fainting?_____ 11. ☐ Yes ☐ No
12. Have you ever had any radiation treatments for cancer?_____ 12. ☐ Yes ☐ No
13. Have you ever been treated for depression?_____ 13. ☐ Yes ☐ No
14. Have you ever had an allergic reaction to anesthetics?_____ 14. ☐ Yes ☐ No
15. Do you have pain in or near your ears?_____ 15. ☐ Yes ☐ No
16. Do your gums bleed?_____ 16. ☐ Yes ☐ No
17. Do you at the present time have any dental complaints? If so, what?_____ 17. ☐ Yes ☐ No

    _____
18. When was your last full mouth X-ray taken? Where?_____ 18. ☐ Yes ☐ No

The information given about the medical history of the patient is accurate. I understand that inaccuracy of the medical information/history given could adversely affect the outcome of the dental procedure(s) performed.

_____ _____

Patient or Parent/Guardian Signature Date