LAKE MICHIGAN DENTAL, P.C.

PATIENT REGISTRATION

Date: _____

Patient Name: _____ M: ☐ F: ☐ Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐

Residence Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ SS Number: _____ Patient Birth Date: _____

If Patient is a Child, Parent's Name: _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ SS Number: _____ Parent Birth Date: _____

Spouse Name: _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ SS Number: _____ Spouse Birth Date: _____

Whom May We Contact in Case of Emergency Name: _____ Phone: _____

Whom May We Thank for Referring You to Us? _____ Relationship: _____

Is Any Member of Your Immediate Family a Patient Here? Y: ☐ N: ☐

If Yes, Name: _____

Who Will Be Financially Responsible for This Account? _____

Account Will Be Paid Today by Cash: ☐ Check: ☐ Credit Card: ☐

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE

Primary Insurance: Name of Insured _____ Insurance Company: _____

Employer: _____ Group #: _____ Member #: _____ Birth Date: _____

Secondary Insurance: Name of Insured _____ Insurance Company: _____

Employer: _____ Group #: _____ Member #: _____ Birth Date: _____

We make every effort to keep down the cost of your dental care. You can help by paying for treatment at the time of your visit. Payment for services is due at the time services are rendered unless financial arrangements are made with our business staff.

If you have dental insurance, remember that your insurance is a contract between you, your employer, and the insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. The insurance company payment, that portion of the fee which is payable by the patient, is due at the time of service.

We do not share any information with anyone not directly involved with patient care.

AUTHORIZATION and RELEASE

I authorize the doctor to release any information, including the diagnosis and the records on any treatment or examination rendered on my behalf during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor, or doctor's group, insurance benefits otherwise payable to me.

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

Has there been any problem in your general health within the past five (5) years? Y: ☐ N: ☐

If yes, when & what was the problem? _____

Date of Last Medical Checkup: _____ Dental Checkup: _____

Are you under a physician's care now? _____ For what: _____

Physician's Name: _____ Phone: _____

Are You Taking any of the Following:

Antibiotics/Sulfa Drugs	Y: ☐ N: ☐	Tranquilizers	Y: ☐ N: ☐
Blood Thinners	Y: ☐ N: ☐	Insulin/Other Diabetes Drugs	Y: ☐ N: ☐
Blood Pressure Medications	Y: ☐ N: ☐	Digitalis/Other Heart Medications	Y: ☐ N: ☐
Thyroid Medication	Y: ☐ N: ☐	Nitroglycerin	Y: ☐ N: ☐
Cortisone/Steroids	Y: ☐ N: ☐	Aspirin	Y: ☐ N: ☐
Antihistamine/Allergy/Cold Remedies	Y: ☐ N: ☐	Over the Counter Medications/Nutritional Supplements	
Osteoporosis Medications	Y: ☐ N: ☐		Y: ☐ N: ☐

Please List name of Medication(s) and Dosage(s) below:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do You Have or have You Had:

Acid Reflux	Y: ☐ N: ☐	Chemotherapy	Y: ☐ N: ☐
Arthritis	Y: ☐ N: ☐	Radiation Treatment	Y: ☐ N: ☐
Diabetes	Y: ☐ N: ☐	Artificial Heart Valve	Y: ☐ N: ☐
Epilepsy	Y: ☐ N: ☐	Artificial Joint	Y: ☐ N: ☐
Hepatitis	Y: ☐ N: ☐	Is Your Mouth Very Dry	Y: ☐ N: ☐
Liver Disease	Y: ☐ N: ☐	Do You Wake w/ Frequent Headaches	Y: ☐ N: ☐
Kidney Disease	Y: ☐ N: ☐	Any Other Condition / Treatment	Y: ☐ N: ☐
Rheumatic Heart Disease	Y: ☐ N: ☐	_____	
High Blood Pressure	Y: ☐ N: ☐		
Stroke	Y: ☐ N: ☐	**Are You Allergic To:**	
Asthma	Y: ☐ N: ☐	Latex	Y: ☐ N: ☐
Lung Problems	Y: ☐ N: ☐	Penicillin	Y: ☐ N: ☐
Tuberculosis	Y: ☐ N: ☐	Codeine	Y: ☐ N: ☐
Abnormal Bleeding	Y: ☐ N: ☐	Local Anesthetic	Y: ☐ N: ☐
Abnormal Heart Condition	Y: ☐ N: ☐	Other Drugs	Y: ☐ N: ☐
Heart Murmur	Y: ☐ N: ☐	_____	
Anemia, Blood Disorders	Y: ☐ N: ☐		
		Are You Pregnant?	Y: ☐ N: ☐
		Due Date: _____	

Is there anything about your teeth/smile you are unhappy with or would like to change? _____

_____

Are you having any dental pain or discomfort? _____

Signature: _____

Personal Interview: _____ Medical Update: _____