

**ADULT**

**REGISTRATION HISTORY**

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ M/F \_\_\_\_\_ SINGLE \_\_\_\_\_

NICKNAME \_\_\_\_\_ HM PH \_\_\_\_\_ CELL \_\_\_\_\_ WIDOWED \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ MARRIED \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ DIVORCED \_\_\_\_\_

PATIENT EMPLOYED BY \_\_\_\_\_ PHONE \_\_\_\_\_ SEPARATED \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

PATIENT'S SOCIAL SECURITY # \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_

EMAIL \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_ WK PH \_\_\_\_\_ CELL \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

SPOUSE'S SOCIAL SECURITY NUMBER \_\_\_\_\_

EMERGENCY CONTACT (Other than yourself or spouse) NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU \_\_\_\_\_

**INSURANCE INFORMATION**

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR SERVICES? YES \_\_\_\_\_ NO \_\_\_\_\_

PATIENT'S PRIMARY CARRIER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ B/DATE \_\_\_\_\_ SS# \_\_\_\_\_

SUBSCRIBER EMPLOYED BY \_\_\_\_\_

CARRIER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

I authorize release of information relating to treatment received by F. Mike Farley, DDS/David C. Mace, DDS. I understand that I am responsible for all costs of treatment.

I hereby authorize payment directly to F. Mike Farley, DDS/David C. Mace, DDS of group insurance benefits otherwise payable to me.

\_\_\_\_\_ patient signature

\_\_\_\_\_ patient signature

PATIENT'S SECONDARY CARRIER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
(company name)

SUBSCRIBER'S NAME \_\_\_\_\_ B/DATE \_\_\_\_\_ SS# \_\_\_\_\_

SUBSCRIBER EMPLOYED BY \_\_\_\_\_

CARRIER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

I authorize release of information relating to treatment received by F. Mike Farley, DDS/David C. Mace, DDS. I understand that I am responsible for all costs of treatment.

I hereby authorize payment directly to F. Mike Farley, DDS/David C. Mace, DDS of group insurance benefits otherwise payable to me.

\_\_\_\_\_ patient signature

\_\_\_\_\_ patient signature

*Please be advised that we require 24 hours notice for cancelling an appointment, otherwise there may be a charge for the time reserved.*

## MEDICAL HISTORY

Have you now or ever had any of the following diseases or conditions?

(PLEASE CHECK)	NO	YES
Heart Trouble or Rheumatic Fever .....	_____	_____
Bleeding Trouble .....	_____	_____
Anemia .....	_____	_____
High Blood Pressure .....	_____	_____
Diabetes .....	_____	_____
T. B. (Tuberculosis) .....	_____	_____
Asthma .....	_____	_____
Nervous Disorder .....	_____	_____
Hepatitis (Jaundice) .....	_____	_____
Kidney - Gastro Intestinal .....	_____	_____
Glaucoma .....	_____	_____
Aids/HIV .....	_____	_____

Are you Allergic to any of the following ?

(PLEASE CHECK)	NO	YES
Penicillin .....	_____	_____
Sulfa .....	_____	_____
Codeine .....	_____	_____
Local Anesthetic .....	_____	_____
Aspirin .....	_____	_____
Other Drugs .....	_____	_____
Are You at this Time Under the Care of a Physician? .....	_____	_____
If So, for What? _____		
Name of your Physician _____		

Do you use tobacco products? \_\_\_\_\_

Have you ever had any type of venereal disease? \_\_\_\_\_

Do you use alcohol? \_\_\_\_\_

Have you ever had joint replacement surgery? \_\_\_\_\_

If yes, how much & how often? \_\_\_\_\_

If yes which joint & when? \_\_\_\_\_

Have you had trouble with prolonged bleeding? \_\_\_\_\_

When was your last medical examination? \_\_\_\_\_

Please describe any current medical condition or treatment, including any medications you are taking:

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## DENTAL HISTORY

Are you having discomfort at this time? \_\_\_\_\_

When was your last visit to a dentist? \_\_\_\_\_

Would you like whiter teeth? \_\_\_\_\_

On your previous dental visit:	NO	YES	Do you have a history of:	NO	YES
Were you given a local anesthetic .....	_____	_____	Headaches .....	_____	_____
Were x-rays taken .....	_____	_____	Pain in your jaws or ears .....	_____	_____
Were home care instructions given .....	_____	_____	Clicking or popping jaw joints .....	_____	_____
Were regular preventive visits made .....	_____	_____	Dizziness or light-headedness .....	_____	_____
Did you have any decay .....	_____	_____	Biting hard objects .....	_____	_____
Were there any special problems .....	_____	_____	Food collecting between teeth .....	_____	_____
If so what? _____					

Is there sensitivity in your mouth to: Heat \_\_\_\_\_ Cold \_\_\_\_\_ Sweets \_\_\_\_\_ Chewing \_\_\_\_\_

I hereby authorize treatment for my Dental Health Care.

Signature \_\_\_\_\_