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.

____
patient signature

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'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.

____
patient signature

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

____
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? ____________________

Do you use alcohol? ____________________

If yes, how much & how often? ____________________

Have you had trouble with prolonged bleeding? ____________________

Have you ever had any type of venereal disease? ____________________

Have you ever had joint replacement surgery? ____________________

If yes which joint & when? ____________________

When was your last medical examination? ____________________

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

____

____

____

____

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
Were you given a local anesthetic	____	____
Were x-rays taken	____	____
Were home care instructions given	____	____
Were regular preventive visits made	____	____
Did you have any decay	____	____
Were there any special problems	____	____

Do you have a history of:	NO	YES
Headaches	____	____
Pain in your jaws or ears	____	____
Clicking or popping jaw joints	____	____
Dizziness or light-headedness	____	____
Biting hard objects	____	____
Food collecting between teeth	____	____

If so what? ____________________

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

II hereby authorize treatment for my Dental Health Care.

Signature ____________________