PATIENT REGISTRATION

NAME_____ Date_____
(FIRST) (MIDDLE) (LAST)

REFERRED BY_____

MEDICAL-DENTAL HISTORY

Name of Medical Physician_____ Phone_____

Reason for this visit?_____

How long has it troubled you?_____

Are you under a physician's care now?_____

For what?_____

_____

Previous hospitalization or operation?_____

_____

What drugs or medications are you now taking?_____

_____

What drugs or medicines are you Allergic to?_____

_____

Date of last physical exam_____ Dental exam_____

Age_____ Height_____ Weight_____

Have you had:

Past complications with oral surgery/extractions?	Yes	No
Previous orthodontic treatment (Braces)?	Yes	No
Previous facial or jaw surgery?	Yes	No

Describe_____

_____

Are there now any growths or sores in or around your mouth	Yes	No

Do you have:

Headaches?	Yes	No
Pain the region of the jaw, eye, ear?	Yes	No
Jaw popping, clicking, or locking?	Yes	No
Difficulty opening your jaw?	Yes	No
Grinding or Clenching of teeth	Yes	No

Other _____

_____

Is there anything about the appearance of your face, jaws or teeth that you wish could be improved?_____

_____

_____

_____

WOMEN:

Are you pregnant now?	Yes	No
(Please inform us before X-rays are taken)		
Do you take the birth control pill (oral contraceptive)?	Yes	No

Circle any of the following which you have had or have at present:

Heart Failure	Heart Surgery	Hay Fever	HIV Positive Blood Test	Cold Sores
Heart Disease or Attack	Artificial Joint	Sinus Trouble	Aids or ARC	Genital Herpes
Angina Pectons or Chest Pain	Anemia	Allergies or Hives	Hepatitis A (infectious)	Epilepsy or Seizures
High Blood Pressure	Stroke	Diabetes	Hepatitis B (serum) or C	Fainting or Dizzy Spells
Heart Murmur	Kidney Trouble	Thyroid Disease	Liver Disease	Nervousness
Rheumatic Fever	Ulcers	X-ray or Cobalt Treatment	Yellow Jaundice	Psychiatric Treatment
Congenital Heart Lesions	Emphysema	Chemotherapy (Cancer, Leukemia)	Blood Transfusion	Sickle Cell Disease
Mitral Valve Prolapse	Glaucoma	Arthritis	Drug Addiction	Bruise or Bleed Easily
Artificial Heart Valve	Tuberculosis (TB)	Rheumatism	Hemophilia	Contact Lenses
Heart Pacemaker	Asthma	Cortisone (Steroids) Medicine	Venereal Disease (Syphilis Gonorrhea)	Tobacco Use

Is there anything relating to your medical history that you have not indicated above? If yes, Explain YES NO

_____

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment if indicated. I have read both pages of the patient registration form and answered all questions appropriate.

SIGNATURE: _____ Date_____
(Parent or Guardian if patient is a minor)

COMPLETE FOR SUBSEQUENT VISITS ONLY: I have read my answers to the health history questions listed above and there are no changes

(1) _____ _____ (2) _____ _____ (3) _____ _____ (4) _____ _____
INITIALS DATE INITIALS DATE INITIALS DATE INITIALS DATE

PLEASE PRINT

PATIENT INFORMATION

Patient's Name:_____ Address:_____

Gender: Male Female Date of Birth:_____ _____

Social Security #:_____ City:_____State:_____ Zip:_____

Marital Status: ☐ Married ☐ Single Work Phone: (_____) _____

☐ Divorced ☐ Widowed Home Phone: (_____) _____

Check One: ☐ Employed ☐ Retired Cell Phone: (_____) _____

☐ Full-Time Student ☐ Other Employer: _____

Do you have Dental Insurance? Yes No

Has anyone in your family been a previous patient of Dr. Read?

Please List: _____

DENTAL INSURANCE INFORMATION

Insured/Card Holder's Name: _____ Gender: Male Female

Social Security #:_____ Date of Birth:_____ Relationship:_____

Name of Dental Insurance:_____

MEDICAL INSURANCE INFORMATION

Insured/Card Holder's Name: _____ Gender: Male Femal

Social Security #:_____ **Date of Birth:** _____ Relationship:_____

Name of Medical Insurance:_____

EMERGENCY CONTACT

Name:_____ Home Phone: (_____) _____

Relationship:_____ Work Phone: (_____) _____

Cell Phone: (_____) _____

I authorize my insurance to pay directly to Daniel S. Read, DMD, for services rendered.
As a courtesy to our patients, we are willing to bill your insurance for services. Patients may be responsible for balances on account over 90 days if no payment is received from your insurance.
I hereby acknowledge that I have read a copy of the patient's Notice of Privacy Practices, and I have been given the opportunity to ask questions that I may have regarding this notice. (Available in the office)

Signature_____ Date_____

Daniel S Read, DMD
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Reconstructive Jaw Surgery
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Diplomate, American Board of Oral and

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As a courtesy to our patients we are willing to bill your insurance company, please remember that your insurance is a contract between you and the insurance company, not the doctor.
Patients or responsible party will be responsible for the balance on the account if insurance does not pay within 90 days.

Please see the patient privacy protection act located at our front desk. If you would like a copy of it we will gladly provide you with one.

I, _____, hereby acknowledge that I have read a copy of the patient's NOTICE of PRIVACY PRACTICES. I have been given the opportunity to ask questions I may have regarding this notice.
Due to these laws we will not be able to give out any information. Unless you sign and list names of people allowed to, receive your information.
Information may be given to _____
_____

In the event any person is exposed to my blood or fluids, I consent to the appropriate test for the presence of infection. I will be informed of the results of the test, and they will remain confidential.
Signature_____
Date_____