PATIENT REGISTRATION

NAME _____DATE OF BIRTH _____

HOME ADDRESS _____

CITY _____STATE_____ZIP CODE_____

HOME PHONE # (____) _____ CELL# (____) _____

WORK PHONE # (____) _____ SS # _____-_____-_____

EMAIL ADDRESS _____

PLACE OF EMPLOYMENT _____

MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____

IF MARRIED, SPOUSE'S NAME _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

POLICY HOLDER _____ DATE OF BIRTH _____

SS # _____-_____-_____ ID # _____ GROUP # _____

RELATIONSHIP TO PATIENT _____

PLACE OF EMPLOYMENT _____

INSURANCE CARRIER _____

CLAIMS ADDRESS _____

CLAIMS PHONE # _____

SECONDARY DENTAL INSURANCE

POLICY HOLDER _____DATE OF BIRTH _____

SS # _____-_____-_____ ID # _____ GROUP # _____

RELATIONSHIP TO PATIENT _____

PLACE OF EMPLOYMENT _____

INSURANCE CARRIER _____

CLAIMS ADDRESS _____

CLAIMS PHONE # _____

MEDICAL HISTORY

HAVE YOUR EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THOSE THAT APPLY:

____AIDS	____CHEMOTHERAPY	____LIVER DISEASE
____ALLERGIES	____CHOLESTEROL	____MENTAL DISORDERS
____ANEMIA	____CONGENITAL HEART LESIONS	____MITRAL VALVE PROLAPSE
____ANGINA	____DIABETES	____ORGAN TRANSPLANT
____ARTHRITIS	____EPILEPSY	____PACEMAKER
____ARTIFICIAL HEART VALVES	____GLAUCOMA	____RHEUMATISM
____ARTIFICIAL JOINTS/PINS/PLATES	____HEART DISEASE	____RADIATION THERAPY
____ASTHMA	____HEART MURMUR	____SINUS PROBLEMS
____BLEEDING DISORDERS	____HEPATITIS	____STROKE
____BLOOD PRESSURE	____ KIDNEY DISEASE	____THYROID DISEASE
____CANCER	____LATEX ALLERGY	____ULCERS

LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING: _____ _____

_____ _____ _____

_____ _____ _____

ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? _____ IF YES, PLEASE EXPLAIN:_____

NAME OF YOUR PHYSICIAN: _____ PHONE # _____

HAVE YOU BEEN ADMITTED TO A HOSPITAL OR NEEDED EMERGENCY CARE DURING THE PAST TWO YEARS? _____ IF YES,

PLEASE EXPLAIN:_____

IF FEMALE: ARE YOU TAKING HORMONES OR BIRTH CONTROL? _____ ARE YOU PREGNANT OR NURSING? _____

INFORMED CONSENT: I CONSENT TO RECEIVE SPECIAL CONSULTATION AND SHOULD I AGREE TO ACCEPT PROFESSIONAL ADVICE, ALSO CONSENT TO THE PERFORMING OF WHATEVER DENTAL PROCEDURE MAY BE DECIDED NECESSARY OR ADVISABLE IN THE OPINION OF DR. SORIA. I ALSO ACKNOWLEDGE FULL RESPONSIBLIITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY FOR THEM, IN FULL, AT OR BEFORE COMPLETION, UNLESS OTHER SPECIFIC ARRANGEMENTS ARE MADE WITH THE OFFICE MANAGER. I AUTHORIZE MY INSURANCE CARRIER TO ISSUE THE DENTAL BENEFITS OF MY PLAN DIRECTLY TO THIS DENTAL OFFICE. IF I SHOULD RECEIVE PAYMENT FROM MY INSURANCE COMPANY, I WILL SEND THE CHECK TO THE OFFICE. I ALSO AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS DENTAL INSURANCE. I WILL ALLOW DR. SORIA TO TAKE DENTAL PHOTOGRAPHS, AS NEEDED. I WILL ALLOW DR. SORIA'S OFFICE TO RELEASE AND TRANSFER X-RAYS AND DENTAL RECORDS TO THE APPROPRIATE DENTAL OFFICE, AS NEEDED. THANK YOU.

SIGNATURE:_____ **DATE**:_____