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**:______________________________