#_____

ANCHOR BAY DENTAL ASSOCIATES
PATIENT REGISTRATION AND HEALTH HISTORY

_____ _____ _____ ____/____/____
(PRINT) First Middle Last Name Date of Birth

_____ _____ _____ _____ _____
Street Address City Zip Home Phone Work Phone

I prefer to see: Dr. _____ I have no preference: _____ _____
Cell Phone

We would like to welcome you to our practice, and look forward to providing you with the professional care and treatment that you may request or require, as well as answer any questions you may have concerning such. In doing this, we hope to continue to provide the highest level and range of services that we possibly can. Please assist us by fully completing the **front and back** of this form; if there are any questions, please feel free to ask one of our staff.

(circle)

1. Are you having any pain or discomfort at this time?..... YES NO
2. Have you been hospitalized within the last two years?..... YES NO
3. Have you been under the care of a physician **within the last two years**?..... YES NO

   Physician's Name: _____ Phone: _____
   Reason: _____

4. Within the last two years have you taken, or are you currently taking, **any drugs or medications**?.....YES NO

   If so, please list: _____

5. Are you **allergic** to, or have you had any adverse reactions to any of the following?..... YES NO

   (circle) Aspirin Codeine Darvon Demerol Nitrous Oxide Sulfa Local Anæsthetic
   Erythromycin Penicillin Clindamycin Tetracycline Latex Dental Materials

6. Are you aware of being **allergic** to any other medications or substances?..... YES NO

   If yes, please list: _____

7. Circle any of the following which you have had, or currently have:

Heart Disease/ Failure	Emphysema	AIDS/HIV	Liver Disease
Heart Attack	Tuberculosis	Hepatitis A, B, or C	Jaundice
Angina	Asthma	Cold Sores	Blood Transfusion
High Blood Pressure	Seasonal Allergies	Epilepsy or Seizures	Colitis, G.I. Problems
Heart Murmur	Sinus Problems	Radiation Treatment	Clotting Disorders
Rheumatic Fever	Thyroid Problems	Chemotherapy	Diabetes
Heart Valve Surgery	Arthritis	Cosmetic Surgery	Anemia
Shortness of Breath	Kidney Problems	Artificial Joints	Bruise Easily
Stroke	Ulcers	Heart Pacemaker	Psychiatric Care

CONSENT:

The undersigned hereby authorizes the Doctor(s) to take any essential radiographs, photographs, study models, or any other diagnostic aids deemed necessary and appropriate by the Doctor(s) to facilitate a thorough evaluation and diagnosis of the patient's dental needs. I also authorize the Doctor(s) to perform and provide any and all forms of treatment, medication, and therapy in connection with and agreed to by *(Name of Patient)* _____, and further authorize and consent that the Doctor(s) choose and employ such assistance as he/she deems fit. I also understand the use of anæsthetic agents embodies certain risks. I understand that responsibility for payment for Dental Services provided for myself or my dependents is mine, and is due and payable at the time services are rendered. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect the collection of such debt.

_____ ____/____/____ _____
Patient / Guardian Signature *Date* *Witness*

(Please turn over)

Our office is committed to providing you with the best possible care, and would be happy to answer any questions concerning proposed treatment or financial arrangements for such. We deal with a large number of insurance carriers and programs, and we would be pleased to submit initial claims for you, with your assistance. Please remember, however, that:

1) not all services are covered benefits on all contracts. Some employers and programs arbitrarily select certain services they will not cover, regardless of the indication or need for such.

2) our fees generally fall within the range of what most major insurance carriers consider the usual, customary, and reasonable fees for this region.

3) your insurance coverage is a contract between you, the employer, and the insurance company; our office's relationship is with you, the patient. While the filing of insurance claims is a courtesy we readily extend to our patients, all charges and fees are the responsibility of the patient or responsible party from the date such services are rendered.

Unless other financial arrangements have been previously approved by our Accounts personnel, patient payment is due at the time services are provided, and may be paid with cash, check, or major credit card. In cases where extensive treatment is needed, we would be happy to discuss and arrange different means of handling your account. We also realize that situations may arise which may affect timely payment of your account; if such should occur, we encourage you to contact us promptly for assistance in managing this.

If you should have any questions about the above information or uncertainty regarding insurance coverage, please don't hesitate to ask. Although the patient is responsible for insurance benefits and coverage information, we would be happy to help where we can. We are pleased to have the opportunity to work with you and provide the dental services you may need or request, while maintaining our consistently high level of quality and care.

I understand and agree that, regardless of insurance coverage, I am responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this form and have completed it fully and correctly. I certify that this information is true, to the best of my knowledge, and will notify this office of any changes in my health status, insurance coverage, or any of the above information.

_____ _____

Signature (patient/parent/guardian) *Date*