

Patient Registration Form

FAX BACK to 1-732-907-1711

Patient Name _____ Prefer to be called _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Home Phone(____) _____ Work Phone(____) _____ Other/Cell(____) _____

Date of Birth _____ Age _____ Sex _____ Soc. Sec. # _____ Today's date _____

Employer _____
Name Address Phone

Primary Insurance _____
Name ID# Group# Phone Name of Insured (if different)

Secondary Insurance _____
Name ID# Group# Phone Name of Insured (if different)

Relationship of Patient to Insured (if different) _____ **Referred by** _____

RESPONSIBLE PARTY (if different) _____
First Middle Last Relationship to Patient

Address _____ City _____ State _____ Zip _____ Home phone _____ Work phone _____

Date of Birth _____ Age _____ Sex _____ Soc. Sec. # _____

In case of emergency, who should be notified _____

Allergies to Medications _____ Foods _____

Past Surgeries _____ Reactions to dental anesthesia _____

Current Medications _____

(incl. non-prescription) _____

Do you take daily Aspirin? _____ Ibuprofen? _____ Other blood thinners? _____

Please circle any of the following conditions that you have or have had and elaborate below:

- | | | | |
|--------------------|------------------------|--------------------------|---------------------|
| Heart Murmur | Artificial Heart Valve | Artificial Joint | Metal Prosthetic |
| Pacemaker | Other heart disease | Bleeding disorder | High blood pressure |
| Liver disorder | Kidney disorder | Thyroid disorder | Cancer |
| Asthma/Hay fever/ | Diabetes | Stomach/gastrointestinal | Neurologic |
| Seasonal allergies | HIV/AIDS | Immune disorders | |

Have you had skin cancer _____ Other specific skin diseases _____

Problems with healing _____ Do you develop keloids (excessive scars) after surgery _____ Bleed easily _____

Are you required to take antibiotics before you have a dental cleaning? _____

Any Family History of any medical problems _____

Do you drink alcohol? _____ smoke? _____ (WOMEN) Are you pregnant? _____

I authorize the release of medical information to my referring physician, to consultants if needed, and as necessary to process insurance claims. I authorize payment of medical benefits to the physician. I understand that I am responsible for any amount not covered by insurance.

Patient or Responsible Party Signature _____ Date _____

I have reviewed the HIPAA Notice of Privacy Practices.

Patient or Responsible Party Signature _____ Date _____

Do we have your permission to leave a message on an answering machine _____, to call you at work _____, to discuss with any household members (state whom) _____