PATIENT REGISTRATION INFORMATION
(Please Print)

Patient Name: ____ Home Phone:____________
Last Name First Name Middle Int. Preferred Name

Street Address:__________________________ City: ______________ State:______________ Zip:____________

Sex: ☐M ☐F Age:_____ Birthdate:___________ ☐Child ☐Single ☐Married ☐Divorced ☐Other

SSN#__________________________ Cell Phone:___________________ Pager:___________________________

Employed By:________________________ Occupation:____________________ How Long Employed?______

Business Address:____ Business Phone:___________________

If full-time student, list school name and hours attended per week:____

Who is responsible for this account?_______________________________ Relationship to patient:______________

Spouse/Parent SS#_______________________ Spouse/Parent Birthdate:_______________

Name of dental insurance co:_________________________ Group #:___________ Phone:__________________

Name of policy holder for dental ins. co:_____________________SS#_____________ Birthdate: _______________

If secondary coverage, list name of ins. co:___________________ Group #:______________ Phone: ____________

Name of policy holder for secondary ins. co: ___________________ SS#:__________________ Birthdate:________

In case of emergency, who should we notify?____

Whom may we thank for referring you?____

MEDICAL HISTORY

Have you ever had any of the following? (check all boxes that apply)

☐ Heart Murmur	☐ Epilepsy	☐ Stomach Problems
☐ High Blood Pressure	☐ Headaches	☐ Swollen Neck Glands
☐ Low Blood Pressure	☐ Hepatitis, Jaundice, Liver Disease	☐ Rheumatic Fever
☐ Circulatory Problems	☐ Cancer	☐ Sinus Problems
☐ Nervous System Problems	☐ Psychiatric Care	☐ AIDS/HIV
☐ Radiation Treatment	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Artificial Heart Valve/Joints	☐ Tuberculosis	☐ Stroke
☐ Recent Weight Loss	☐ Allergies to Medicines or Drugs	☐ Ulcer
☐ Back Problems	☐ General Allergies	☐ Venereal Disease
☐ Diabetes	☐ Blood Disease	☐ Chemical Dependency
☐ Respiratory Disease	☐ Arthritis	☐ Homophilia

Have you ever taken Phen Phen or Redux? ☐YES ☐ NO

(Women) Do you suspect you are pregnant? ☐YES ☐ NO Are you nursing? ☐YES ☐ NO

Do you have any drug allergies or have you ever had an adverse reaction to medication? _________________

If so, what? ____

Are you taking medication at this time? □ Yes □ No If so, what?__________________________________

Are you under the care of a physician? □ Yes □ No For what conditions(s)?_________________________

____

If the patient is a child, what is his or her weight?__________________

Is there anything else we should know about your medical history?__________________________________

DENTAL HISTORY

Have you had any sinus trouble associated with any previous dental work? □ Yes □ No

Are you wearing a removable dental appliance? □ Yes □ No

When were you last seen by a dentist?______________________ For what?__________________________

When was your last professional teeth cleaning?___________________________

Have you ever been diagnosed with periodontal disease? □ Yes □ No

PLEASE READ CAREFULLY

I hereby authorize payment directly to Dr. Mike Pulido, otherwise payable to me. A photocopy of my signature may serve as the original. Payment is due when services are rendered. All patient co-payments and deductibles for insurance purposes must be paid at time of visit. This office will assist the patient, if possible, by completing and filing the necessary forms, but the responsible party, by signing below, accepts full responsibility for outstanding balances after thirty (30) days. The responsible party, by signing below, understands and agrees to pay a 1.5% monthly finance charge with a minimum $5.00 balance which has been outstanding in excess of sixty (60) days. All missed appointments or broken appointments without twenty-four (24) hour notice will be subject to a $25.00 charge per missed visit. If this account becomes delinquent or is placed with an attorney for collection, the undersigned responsible party agrees to pay all attorney and collection fees associated with the collection of this bad debt.

Signature of Responsible Party:____ Date:_________________

For subsequent visits only: I have read and reviewed my answers to the medical history and have noted all changes:

1)____________________ 2)_____________________ 3)____________________ 4)____________________

Initials Date Initials Date Initials Date Initials Date