ROBERT T. FERRIS, D.D.S., Ph.D.

☐ 475 Maitland Avenue
Altamonte Springs, Florida 32701
(407) 831-1747

☐ 120 E. New York Avenue, Suite H
Deland, Florida 32724
407-831-1747

PRACTICE LIMITED TO PERIODONTICS

LAST NAME | FIRST NAME | RESIDENCE TELEPHONE | BIRTHDATE | DATE OF EXAM

RESIDENCE ADDRESS | CITY | OCCUPATION

BUSINESS ADDRESS | CITY | BUSINESS TELEPHONE

REFERRED BY | DENTIST'S TELEPHONE

PLEASE COMPLETE THE MEDICAL HISTORY BELOW.

Have any of the following ever applied to you:

Yes	No	
		Heart condition
		Rheumatic fever
		Shortness of breath
		Swelling of ankles
		High blood pressure
		Low blood pressure
		Bleeding disorder
		Blood transfusion
		Irregular pulse
		Pacemaker
		Anemia
		Liver disease
		Arthritis
		Chest surgery
		Bronchitis
		Emphysema
		Asthma
		Tuberculosis
		Kidney Disease
		Frequent Indigestion

Yes	No	
		Hepatitis
		Venereal disease
		HIV tested (AIDS Virus)
		HIV Positive
		Thyroid disease
		Pneumonia
		Diabetes
		Nerve disorder
		Head Injury
		Epilepsy
		Fainting spells
		Glaucoma
		Contact lenses
		Cancer
		Radiation therapy
		Stroke
		Ulcers
		Immune disease
		Substance Abuse
		Emotional Disorder
		Dialysis

Are you presently under the care of a physician? Name _____

Date of last visit to physician _____

Have you been hospitalized in the last 5 years

Have you had an anesthetic in the last year

Have you ever had problems with anesthesia

Do you have any prosthetic joints, heart valves, or implants

Do you smoke? Packs/Day _____

Do you take aspirin daily

Do you have any other illnesses

List _____

Have you ever taken any of the following drugs:

Yes	No	
		Digitalis (heart)
		Nitroglycerin
		Sedatives
		Steroids (cortisone)
		Tranquilizers
		Blood thinners
		Insulin
		Dilantin
		Antibiotics
		Vitamins
		Birth control pills

Are you presently taking any other medications? _____

Allergic to any drugs? _____

Any other allergies (Latex Gloves, Etc.) _____

Are you now pregnant _____ Months _____

Have you reached menopause? _____

Weight _____ Height _____

Remarks:

I hereby authorize the doctor in charge of the treatment of the above named to administer any treatment or administer any necessary anesthetic and perform such operations as may be deemed necessary or advisable in the diagnosis or treatment of this patient. I certify that the above medical information is correct.

Patient's Signature _____

Date _____

FOR OFFICE USE

Pulse _____

B/P _____

Bleeding time _____

Clotting time _____

G.T.T. _____

PATIENT REGISTRATION

(TO BE FILLED IN COMPLETELY)

Date _____

Patient _____
Last First Middle

Date of Birth _____ Social Security Number _____

Responsible Party _____
(Full name of person responsible for payment of services)

If patient is a minor or another person is responsible - show following information regarding responsible party. Otherwise, show information regarding patient.

☐ Married ☐ Divorced ☐ Widow (NAME OF HUSBAND OR WIFE)
☐ Single ☐ Separated ☐ Widower _____

Residence Address _____

Previous Address _____

Employer _____ Occupation _____

Employers Address _____

Employers of Spouse _____ Occupation _____

Employers Address _____

Nearest Relative Not Living With You _____

Address Relative _____

Name of Dental Insurance Company _____

Effective Date of Coverage _____ Policy/Group Number _____

ALL CHARGES FOR YOUR TREATMENT MAY BE HANDLED IN THE FOLLOWING WAYS:

1) **IF YOU DO NOT HAVE DENTAL INSURANCE,** payment is expected when treatment is rendered unless prior financial arrangements are made.

2) **DENTAL INSURANCE POLICY:**

A. Unless prior financial arrangements have been made, each guarantor, not the insurance company, is responsible for payment of all charges to their account at the time services are rendered. We will of course assist you in filling out your dental claims. Your eventual reimbursement will be determined by YOUR insurance carrier.

B. If this office agrees to accept assignment of benefits from the insurance carrier and we do not receive payment within 45 days from date of filing, THE PATIENT IS RESPONSIBLE FOR ANY BALANCE DUE, REGARDLESS OF INSURANCE PENDING.

_____ _____
Date Patient/Guarantor's Signature