ARLINGTON DENTAL CENTER

931 ARLINGTON
ADA, OK 74820

PATIENT REGISTRATION

PATIENT NAME: ________________________ SEX: __________ Date of Birth __________

Age ______ Height ____________ Weight __________ Social Security # ________________

Address: ______________________________ City ____________ State _____ Zip __________

Home Telephone (____)__________________Cell Phone_____________ E-Mail________________

Marital Status ______________ Hobbies/Interests ______________________________

Employed By: ______________________________ Present Position ____________________

Business Address ______________________________ Phone Number __________EXT______

Referred By: Name of other: Patient __________________ Dentist ____________________

Friend ______________ Relative _____________ Phone Book ______ Advertisement ______

In EMERGENCY NOTIFY: Name, Address, Phone Number, and Relationship to patient

____

SPOUSE INFORMATION

Spouse's Name ________________________ Spouse's Date of Birth _________ Spouse SS# _________

Employed by ______________________________ Present Position ____________________

Business Address ______________________________ Phone ____________________

Do you have dental insurance? Yes _____ No _____

PRIMARY INSURANCE

SUBSCRIBER (Name of who has the insurance) __________________EMPLOYER:________________

INSURANCE COMPANY ________________________ POLICY # _________GROUP # _________

INSURED'S BIRTH DATE ____________INSURED'S SOCIAL SECURITY OR ID UMBER________________

SECONDARY INSURANCE

INSURED (who has the insurance?) ____________________EMPLOYER ____________________

INSURANCE COMPANY ____________________ POLICY # ____________GROUP # _________

INSURED'S DATE OF BIRTH ____________INSURED'S SOCIAL SECURITY OR ID NUMBER ____________

RESPONSIBLE PARTY

SIGNATURE OF PERSON RESPONSIBLE FOR PAYMENT OF DENTAL ACCOUNT FOR THE ABOVE NAMED PATIENT. PAYMENT IS EXPECTED AT TIME OF SERVICE. ESTIMATED INSURANCE BENEFITS IS NOT A GUARANTEE OF INSURANCE PAYMENT. I UNDERSTAND I AM RESPONSIBLE FOR THIS ACCOUNT INCLUDING ANY AMOUNT INSURANCE DOES NOT PAY.

SIGNED: ____ DATE ____________________

FINANCE CHARGE: 1.5% PER MONTH ON PAST DUE ACCOUNTS. 18% ANNUAL PERCENTAGE RATE

FOR UPDATING ON SUBSEQUENT VISITS ONLY:

1	2	3	4	5
INITIALS DATE	INITIALS DATE	INITIALS DATE	INITIALS DATE	INITIALS DATE

6	7	8	9	10
INITIALS DATE	INITIALS DATE	INITIALS DATE	INITIALS DATE	INITIALS DATE

ARLINGTON DENTAL CENTER
BRUCE A. HALL, DDS
931 ARLINGTON, ADA, OK 74820

PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME________________________________PATIENT HEIGHT___________PATIENT WEIGHT ________

PLEASE ANSWER BY CIRCLING EITHER YES OR NO TO THE FOLLOWING QUESTIONS OR CHECKING THE APPROPRIATE ITEMS

(Answers to the following questions are for our records only and will be kept confidential)

YES NO 1. Are you in good health? ______________________________

YES NO 2. Have there been any changes in your general health over the past year? ______________

3. My last physical examination was on _(date)______________________________

YES NO 4. Are you now under the care of a physician? ______________________________

5. If so, what condition are you being treated for? ______________________________

Name, address, phone number of your physician ______________________________

YES NO 6. Have you had any serious illness or operation? ______________________________

7. **CHECK** any of the following which you have had or have at present:

__Allergies
__Arteriosclerosis
__Arthritis
__Asthma
__Blood Transfusion
__Cancer
__Congenital heart lesions or HEART MURMUR
__Diabetes
__Emphysema
__Fainting spells or Seizures
__Hay Fever
__Heart disease or Attack
__Heart Failure
__Heart Pacemaker
__Heart Surgery
__Hepatitis
__High blood pressure
__HIV Positive, AIDS
__Hives or Skin rash
__Inflammatory Rheumatism (painful swollen joints)
__Jaundice
__Kidney trouble
__Liver disease
__Low Blood Pressure
__Prosthetic joint replacement surgery
__Rheumatic fever or Rheumatic heart disease
__Stomach Ulcers
__Stroke
__Tuberculosis
__Venereal disease
__Any other we need to know about? _______
____
___None

YES NO 8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ______________

YES NO 9. Do you bruise easily? ______________________________

YES NO 10. Do you have any blood disorder such as anemia? ______________________________

YES NO 11. Have you had surgery or x-ray treatment for a tumor, growth or other condition of the head or neck? ________

YES NO 12. Are you taking or HAVE YOU EVER TAKEN Fen-phen (Pondimin or Redux)? ____________________

(OVER)

13. **CHECK** any of the following that you are taking:

__Antibiotics or Sulfa drugs?
__Anticoagulants (blood thinner)
__Antihistamines
__Aspirin
__Cortisone (steroids)
__Digitalis or drugs for heart trouble
__Fen-phen or any other diet drug
__Insulin, Tolbutamide (Orinase) or similar drug
__Medicine for high blood pressure
__Nitroglycerine
__Oral Contraceptives or hormone therapy. **Note: Antibiotics may render oral contraceptives ineffective.**
__Tranquilizers
__None

List any other drugs you are taking____

____

14. **CHECK** any of the following that you are ALLERGIC to or have REACTED ADVERSELY to:

__Local anesthesia ______________________
__Penicillin or other antibiotics______________
__Sulfa drugs__________________________
__Barbiturates, sedatives, or sleeping pills_______
__Aspirin_____________________________
__Iodine____________________________
__Codeine or other narcotic______________
__Latex_____________________________
__None

List any other **medications or metals** you are allergic to:_____________________________

YES NO 15. Have you had any trouble associated with any previous dental treatment? ____________
YES NO 16. Have you ever required pre-medication for any previous dental treatment? ____________
YES NO 17. Do you have any disease, condition, or problem not listed that you think we should know of? If so, what?
____
YES NO 18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ________
YES NO 19. Are you wearing contact lenses? ____________________________________
YES NO 20. Do you smoke? ____
YES NO 21. Do you use alcohol on a regular basis? ______________________________
YES NO 22. WOMEN: Are you pregnant? _______________________________________
YES NO 23. Do you take or have you taken Fosamax, Boniva,Actonel or other drug containing Bisphosphonates____________

PURPOSE OF THIS CALL: ____

PREVIOUS DENTIST: ______________________________ CITY_____________________

X ____

PATIENT, PARENT, OR GUARDIAN SIGNATURE DATE____________________
(CIRCLE ONE)

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