WILLOW family dental

Whom may we thank for referring you?

How would you like us to contact you regarding needed appointments? Email

Patient Information

Gender: Female

Date:

Title | First | MI | Last | Date of Birth: | School/Grade

Home Address: Street Address | City | State | Zip Code

Mother's Information

Title | First | MI | Last | Date of Birth: | Social Security Number: | Driver's License #

Contact Info: Home | Cell | Work | Email Address

Home Address: Street Address | City | State | Zip Code

Employer Information:

Insurance Carrier: Name of Carrier | Group # | Patient ID#

Father's Information

Title | First | MI | Last | Date of Birth: | Social Security Number: | Driver's License #

Contact Info: Home | Cell | Work | Email Address

Home Address: Street Address | City | State | Zip Code

Employer Information:

Insurance Carrier: Name of Carrier | Group # | Patient ID#

Emergency Contact

Nearest relative not living with you? | Home Phone | Cell Phone | Relation

Dental History Information

Name of Previous Dentist: | City/State

Date of Last Exam | Date of Last Cleaning | Date of Last X-rays | How often do you brush your teeth? | How often do you Floss your teeth?

Do you have any of the following:

Bad Breath No	Smoke or use tobacco products No	Bite Lips/Cheek No	Sensitivity Hot/Cold/ Sweets/Biting No
Bleeding Gums No	Chew on one side mouth No	Food caught between teeth No	Clicking or Popping in Jaw No
Does your child still use a bottle when sleeping? No	Use Pacifier or suck thumb No		

General Health Information

Name of Physician:	Phone Number:	Date of Last Exam

Is your general health in good condition? No Are you being treated by a physician now? No Have you ever been hospitalized? No

Do you have or have you had?

Aids/HIV No	Epilepsy No	Psychiatric Care No	Pregnant No
Anemia No	Fainting/Dizziness No	Radiation Treatment No	Due Date
Arthritis/Rheumatism No	Glaucoma No	Respiratory Disease No	Nursing No
Artificial Heart Valve No	Headaches No	Rheumatic/Scarlet Fever No	Taking Birth Control Pills No
Back Problems No	Heart Murmur No	Sinus Trouble No	Taking Coumadin/Warfarin No
Excessive Bleeding No	Heart Problems No	Skin Rash No	Medications/Vitamins Taking
Blood Disorder No	Hepatitis No	Special Diet No	
Cancer No	Herpes No	Fen-Phen/Diet Drugs No	
Chemical Dependency No	High Blood Pressure No	Stroke No	Aspirin Allergy No
Chemotherapy No	Jaundice No	Swollen ankles/feet No	Barbiturate Allergy No
Circulatory Problems No	Jaw Pain No	Swollen neck glands No	Codeine Allergy No
Congenital Heart Lesions No	Kidney Disease No	Thyroid Problems No	Iodine Allergy No
Cortisone Treatments No	Low Blood Pressure No	Tonsillitis No	Latex Allergy No
Bloody, persistent cough No	Mitral Valve Prolapse No	Tumors No	Anesthetic Allergy No
Diabetes No	Nervous Problems No	Ulcer No	Sulfa Allergy No
Emphysema No	Pacemaker No	Venereal Disease No	Other Allergies
Artificial Joint No	Unexplained Weight Loss No	Wear Contact lenses Email	Penicillin Allergy No

Medical History Reviewed.

Provider Signature: _____ Date:_____

Authorization

I certify that the personal, medical and insurance information I have given on this registration form to be correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it's my responsibility to inform this office of any changes to my personal, insurance and medical status.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate by this office.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependents to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance company to submit payment directly to the dentist or dental practice.

I authorize the dentist and office staff to discuss my treatment, account history and/or payment arrangements with my spouse or domestic partner unless I specifically advise them not to.

I understand and agree to give this office a minimum of 24 hours notice should I need to cancel an appointment, 48 hours notice for Saturday appointments. If notice is not given I understand that a missed appointment fee of $50.00 may be charged to my account.

I understand that I am financially responsible for any outstanding balance for services provided regardless of insurance status. Account Balances which are not paid within 30 days of statement will be subject to a 1% interest charge per month.

Parent or Guardian Signature: _____ Date: _____