DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

MARION DENTAL HEALTH ASSOCIATES, P.C.
3 Spring St. / P.O. Box 949
Marion, MA 02738

Telephone: (508) 748-0744

PATIENT INFORMATION

Name ______________________________ Soc. Sec. # ______________
Last Name First Name Initial

Address ______________________ P.O. Box ________ Phone # ____________ Cell# ____________

City ______________________ State ________ Zip __________ Email ______________

Sex ❑ M ❑ F Age ________ Birthdate ______________ ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Student

Patient Employed by ______________________ Occupation ______________ School __________

Business Address ______________________ Business Phone ______________

Who may we thank for referring you? ______________________________

In case of emergency who should be notified? ______________________ Phone ______________

ACCOUNT INFORMATION

Person Responsible for Account ______________________________
Last Name First Name Initial

Relation to Patient ______________________ Birthdate ______________ Soc. Sec. # ______________

Billing Address ______________________________ Phone ______________

City ______________________ State ______________ Zip ______________

Person Responsible Employed by ______________________ Occupation ______________

Business Address ______________________ Business Phone ______________

DENTAL INSURANCE INFORMATION

Subscriber Name ______________________ Relation to Patient ______________ Birthdate ______________

Subscriber Employed by ______________________ Business Phone ______________

Insurance Company ______________________ Soc. Sec. # ______________

Group # ______________________ Subscriber # ______________________

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name ______________________ Relation to Patient ______________ Birthdate ______________

Address (If different from patient's) ______________________ Phone ______________

City ______________________ State ______________ Zip ______________

Subscriber Employed by ______________________ Business Phone ______________

Insurance Company ______________________ Soc. Sec. # ______________

Group # ______________________ Subscriber # ______________________

PERSON RESPONSIBLE FOR ACCOUNT AND INSURANCE RELEASE

I understand that I am financially responsible for all charges (whether or not paid by insurance.) I, the undersigned certify that I (or my dependent) have

insurance coverage with ______________________________ and assign directly to MARION DENTAL HEALTH
Name of Insurance Company(ies)

ASSOCIATES, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________ ______________________ ______________________
Responsible Party Signature Relationship Date

DENTAL HEALTH HISTORY

Previous Dentist's Name ______________________ Date of Last Visit ______________

Reason for Today's Visit ____

Contact Person In Case of Emergency: Name ______________ Phone ______________________

Physician's Name ______________________ Date of Last Examination ______________________

Are you currently under the care of a physician: YES ___ NO ___ Please explain: ______________________

Are you taking any prescription / over the counter medication? YES ___ NO ___ Please list each one: ______________________

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Are you currently taking blood thinners? YES ___ NO ___ Do you bruise or bleed easily? YES ___ NO ___

Do you require antibiotics before dental treatment? YES ___ NO ___ Do you smoke or use tobacco in any form? YES ___ NO ______________

For Women: Are you taking birth control pills? YES ___ NO ___ Are you pregnant? YES ___ NO ___ Week # ___ Nursing? YES ___ NO ___

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING DISEASES OR MEDICAL CONDITIONS?

	YES	NO		YES	NO
AIDS/HIV	❑	❑	HEART ATTACK / STROKE	❑	❑
ANEMIA	❑	❑	HEART MURMUR	❑	❑
ALCOHOL / DRUG DEPENDENCY	❑	❑	HEART SURGERY / PACEMAKER	❑	❑
ARTIFICIAL:			HEMOPHILIA / ABNORMAL BLEEDING	❑	❑
Bones / Joints	❑	❑	HEPATITIS	❑	❑
Heart Valves	❑	❑	HIGH / LOW BLOOD PRESSURE	❑	❑
ARTHRITIS	❑	❑	JAW PAIN	❑	❑
ASTHMA	❑	❑	KIDNEY DISEASE	❑	❑
BACK PROBLEMS	❑	❑	MITRAL VALVE PROLAPSE	❑	❑
BLOOD TRANSFUSION	❑	❑	NERVOUS PROBLEMS	❑	❑
CANCER RADIATION / CHEMO	❑	❑	PSYCHIATRIC PROBLEMS	❑	❑
CONGENITAL HEART FAILURE	❑	❑	RESPIRATORY PROBLEMS	❑	❑
CIRCULATORY PROBLEMS	❑	❑	RHEUMATIC / SCARLET FEVER	❑	❑
CORTISONE TREATMENTS	❑	❑	SHINGLES	❑	❑
DIABETES	❑	❑	SINUS PROBLEMS	❑	❑
EPILEPSY / SEIZURES	❑	❑	TUBERCULOSIS	❑	❑
FEVER BLISTERS / HERPES	❑	❑	ULCERS / COLITIS	❑	❑
HEADACHES	❑	❑	VENEREAL DISEASE	❑	❑
DIFFICULTY WITH ANESTHESIA	❑	❑	OSTEOPOROSIS/BONE DISORDER	❑	❑

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

	YES	NO		YES	NO
ASPIRIN	❑	❑	LATEX	❑	❑
CODEINE	❑	❑	PENICILLIN	❑	❑
DENTAL ANESTHETICS	❑	❑	SULFA	❑	❑
ERYTHROMYCIN	❑	❑	TETRACYCLINE	❑	❑

Other Allergies? ____

I understand that the following information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is in my responsibility to inform Marion Dental Health of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature ______________________________ Date ______________

Doctor's Comments ____

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