Patient Registration

Jay C. McConnell, D.D.S.

Patient Information Name	
Address	
City	State Zip
Home Phone	Business Phone
Employer	Job Title
Business Address	Zip
Social Security Number	Date of Birth
Referring Doctor	

Spouse Information Name	Business Phone
Employer	
Address	Zip

Dental Insurance Information Employee	Soc. Sec. # Date of Birth
Employer	Group #
Employer Address	
Insurance Company	
Insurance Co. Address & Phone #	

Health History

Do you have, or have you ever had:

Yes	No	
		Epilepsy
		Rheumatic Fever
		Heart Trouble/Murmur
		High Blood Pressure
		Breathing Problems
		Anemia
		Bleeding Problems, Excessive
		Hepatitis
		Positive HIV (AIDS) Antibody Test
		Diabetes/Insulin Dependent

Yes	No	
		Hay Fever
		Asthma
		Sinusitis
		Radiation Treatments
		Cancer or Tumor ______
		Frequent Headaches
		Tuberculosis
		Alcoholism or Drug Abuse
		Psychological/Emotional Problems
		Artificial Joint/Heart Valve

Are you under the care of a physician? Yes No

If yes, what condition is being treated? ______

My physician is ______

(Women) Are you pregnant now? Yes No

Have you ever had an allergic reaction to an anesthetic, drug or latex? ______

If so, please list ______

Other physical conditions which might affect your treatment: ______

Please list all medications you are currently taking.

______

For your convenience, we will file your primary insurance for you at the time of your visit. Please understand that we are not acting as an agent for either party, and are not responsible for any benefits paid. We ask that all services be paid for by the time services have been completed. We accept Visa, Master Card, Discover, and American Express. Care Credit is offered as a monthly payment option.

I hereby acknowledge that all statements made on this sheet (front & back) are accurate and true to the best of my knowledge. I agree to update the office promptly should any of the information on this registration change. I agree to take full responsibility for payment of all services that I or my dependent have incurred at this office. I agree to pay interest on any overdue balance at the rate of 1.31% per month. I have read and agree to the above stated office policies. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

X ______ Date ______