KEOWEE FAMILY DENTISTRY, PA

MICHAEL H. DAVIS, DMD, FAGD

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JOHN H. ATCHESON, DMD

Patient ID#: ____________________

PATIENT REGISTRATION

PATIENTS FULL NAME: ______________________ Name you prefer to be called: ______________

Street/PO Box:		Address 2:
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:

Sex: _____Male _____Female Marital Status: _____Married _____Single _____Separated _____Divorced _____Widowed

Birth Date: ______________ Age: __________ Social Security Number: ______________________

Employer: ______________________________ Employer Phone #: ______________________

Emergency Contact: ______________________ Phone #: ______________ Relation: __________

Do you have any Immediate Family Member/s that are patients with us? _____Yes _____No

If yes, Please tell us their names: ____

____

Referred to our office by: ______________________________________

Preferred Dentist: ______________________ Preferred Hygienist: ______________________

Preferred Pharmacy: ______________________ Pharmacy Phone #: ______________________

RESPONSIBLE PARTY FOR THIS ACCOUNT (THIS PERSON WILL ALSO SIGN THE FINANCIAL POLICY)

First Name: ______________ Last Name: ______________ Relation to patient: ______________

Street/PO Box: ______________________ Address 2: ______________________

City, State, Zip: ____

Home Phone: ____________Cell Phone: ______________ Work Phone: ____________Ext:______

Birth Date: ______________ Social Security #: ______________________

PRIMARY POLICY HOLDER INSURANCE INFORMATION

Name of Policy Holder: ______________________ Relationship to Patient: ______________

Employer: ______________________Employer Phone #: ______________Ext:__________

Group #: ______________________________ ID #: ______________________

Policy Holder Address: ____

Policy Holder Birth Date: ______________________ Policy Holder SSN: ______________

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: ______________________ Relationship to Patient: ______________

Employer: ______________________Employer Phone #: ____________Ext:______________

Group #: ______________________________ ID #: ______________________

Policy Holder Address: ____

Policy Holder Birth Date: ______________________ Policy Holder SSN: ______________

By signing below I hereby authorize any advisable dental procedures, x-rays, medications or anesthetics to be administered by the dentist or staff for diagnostic purposes or dental treatment for the above listed patient.

Patient/Guardian Signature: ______________________________ Date: ______________________

PATIENT ID #: ____________________

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following health related questions:

Please circle the appropriate answer. If YES please describe.

Are you currently under a Physician's care? Yes No Physician's Name: ____________________

Have you EVER been hospitalized or had major operation? Yes No ____________________

Have you EVER had serious Head or Neck Injury? Yes No ____________________

Are you currently taking ANY Medication; Prescribed or OTC? Yes No ____________________

____

____

Are you or have you ever taken Phen-Fen or Redux? Yes No ____________________

Are you or have you ever taken Fosamax, Boniva, Actonel or any other Bisphosphonates? Yes No ____________________

Do you use Tobacco? Yes No ____________________

Women: Are you Pregnant or trying to get Pregnant? Yes No

Are you nursing? Yes No

Are you taking Oral Contraceptives? Yes No

ALLERGIES

Circle ALL that may apply:

Are you allergic to any of the following medications:

ASPIRIN PENICILLIN CODEINE ACRYLIC METAL LATEX LOCAL ANESTHETICS SULFA DRUGS

OTHER NOT LISTED: ____________________

Do you have, or have you ever had, any of the following?

Circle ALL that apply:

AIDS/HIV Positive	Chest Pains	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Dis.	Cold Sores/Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sickle Cell Dis.
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart/Attack/Failure	Low Blood Pressure	Spina Bifida
Arthritis/Gout	Diabetes	Heart Murmur	Lung Dis.	Stomach/Intestinal Dis.
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	Mitral Valve Prolapse	Stroke
Artificial Joint	Easily Winded	Heart Trouble/Dis.	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Dis.	Thyroid Dis.
Blood Dis.	Epilepsy or Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiation Treatment	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors/Growths
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives or Rash	Rheumatic Fever	Venereal Dis.
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

Have you ever had a serious illness not listed above? YES NO ____________________

The above information is true and complete to the best of my knowledge. ____________________ Please Initial

I certify by signing below that I have been given a copy of the office's Notice of Privacy Practices.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature: ____________________

Staff Signature: ____________________ **Today's Date:** ____________________

Dentist Signature: ____________________