SUNRISE
Family Dental Care

PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Date _____ Cell Phone _____

Home Phone _____

E-Mail Address _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: ❑ M ❑ F Age____ Birthdate_____ Driver's License#_____ ☐ Single ☐ Married ☐ Divorced

Patient Employed by _____ Patient Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Patient Social Security # _____ Spouse/Parent Social Security # _____

Dental Insurance Company 1) _____ 2) _____ Group #s _____

In Case of Emergency, Contact _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check all that apply)

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Latex Allergy
- ☐ Eye Surgery
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicines or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Taking Bisphosphonate Drugs
- ☐ Sinus Problems
- ☐ A.I.D.S. or Other Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia
- ☐ Taking Natural Supplements

Do you have ANY drug allergies or have you ever had an adverse reaction to ANY medication? If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking ANY medication at this time? _____ If so, what? _____

Are you currently under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you Nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

© Sunrise Family Dental Care, P.C., Rev. 03-12

(over please)

PATIENT REGISTRATION & MEDICAL HISTORY

DENTAL HISTORY

Previous Dentist (if applicable) _____ City _____

Date of last cleaning _____ Date of last dental visit_____ Why? _____

Have you had dental x-rays taken during the past three years? ☐ Yes ☐ No If so, what kind: _____

☐ Bitewings (one or two on each side to detect cavities) Date_____

☐ Complete Series (16 x-rays) Date_____

☐ Panorex (sitting or standing and machine moves around head) Date_____

Is there any condition in your mouth that is causing you pain or discomfort? ☐ Yes ☐ No If yes, what kind:_____

_____

Do you do any of the following? (check all that apply)

☐ Bite cheeks or lips	☐ Suck fingers	☐ Breathe through mouth	☐ Drink tea/coffee
☐ Bite tongue	☐ Bite fingernails	☐ Tongue thrust	☐ Chew tobacco
☐ Clench teeth	☐ Suck thumb	☐ Notice bad breath frequently	☐ Smoke (cig/pipe)

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

What can we do for you today? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Date_____ Signature_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Sunrise's Providers, all benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. 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 my insurance submissions whether manual or electronic.

_____ _____
Date Signature of Insured/Guardian

MINOR/CHILD CONSENT

I, being the parent or guardian of _____do hereby request and authorize the dental staff
Name of minor/child

to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature of Insured/Guardian

FINANCIAL AGREEMENT

By signing below I acknowledge the following: (1) I am responsible for any and all payments or co-payments for services rendered; (2) Any claims submitted to insurance, which are subsequently declined shall become my responsibility; (3) In the event my owed balance should become delinquent, I acknowledge I may additionally become responsible for additional fees including but not limited to: late fees, collection fees, interest, court costs and attorney fees.

_____ _____
Date Signature of Insured/Guardian