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Welcome!

REGISTRATION FORM

Section I: Patient Information

Date_____

Name:_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

Email Address_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ Social Security Number:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Sex: ☐ M ☐ F

Employer/School_____ Address_____

Spouse or Parent's Name:_____ Employer_____ Work Phone_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____ Relationship to Patient: _____

Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Employer_____ Work Phone (____)_____ SSN#_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

Patient's Name_____ **Date of Birth**_____

Medical History

Patient's Physician_____ Date last seen_____/_____/_____

Have you had a serious illness, operation or been hospitalized in the past 5 years? □ Yes □ No
If yes,explain _____

Have you ever had a blood transfusion? □ Yes □ No If yes, describe_____
Do you smoke or use tobacco? □ Yes □ No

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

List medications you are currently taking and the correlating diagnosis?

_____

Allergies: _____

Please check any medical condition that you have or have had:

□ Arthritis, Rheumatism	□ Asthma	□ Glaucoma
□ Pacemaker	□ High Blood Pressure	□ HIV
□ Artificial Heart Valves	□ Cancer/Chemotherapy/Radiation Treatment	□ Kidney Disease
□ Heart Murmur	□ Headaches/migraines	□ Leukemia
□ Congestive Heart Failure	□ Generalized Anxiety	□ Liver Disease
□ Back Problems	□ Hemophilia	□ Oral Ulcers
□ Cardiovascular disease	□ Bleeding Abnormally	□ Rheumatic Fever
□ Hepatitis or Liver Disease	□ Anemia	□ Stroke
□ Epilepsy	□ Blood Disease	□ Thyroid Problem
□ Fainting spells or seizures	□ Diabetes	□ Tuberculosis

□ Other _____

Dental History

What is the purpose of your dental visit with us today? _____

Former Dentist_____ Date of last dental X-rays _____

Date of your last dental exam: _____ What was done at that time? _____

How often do you brush? _____ How often do you floss? _____

Check if you have had problems with any of the following:

□ Toothaches	□ Tongue Thrusts	□ Bad Breath	□ Food Collection between teeth
□ TMJ (Jaw pain)	□ Bleeding Gums	□ Nail Biting	□ Clenching/Grinding
□ Sensitivity to Cold/Hot	□ Periodontal Treatment	□ Trauma to Tooth/Face/Chin	

I understand that the information that I have given above is correct to the best of my knowledge and that it will be held in the strictest of confidence. It is also my responsibility to inform my doctor if I ever have a change in health.

Authorization and Release

I authorize Dr. Lam to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of Patient, Parent, or Guardian _____Date_____