Robert N. Marley, D.D.S.

Patient Registration and Health Questionnaire

Patient's Name_____ Date of Birth_____ Home Phone_____

SSN_____

Home Address_____ City_____ Zip Code_____

Spouse's Name (or guardian's)_____ Children's Names and Ages_____

Patient's Occupation_____ Work Phone_____

Name of Patient's Physician_____ City_____

Who will be financially responsible for treatment received?_____

Do you have Dental Insurance? _____ Yes _____ No

Name of Dental Insurance Co._____ Policy Holder's I.D. Number_____

Is Spouse covered by another Insurance Company? (Secondary Coverage) _____ Yes _____ No

If Yes, list Insurance Carrier_____ Spouse's Policy I.D. Number_____

Directions

If your answer is YES to the question, put a circle around YES
If your answer is NO to the question, put a circle around NO
Answer all questions and fill in blank space where indicated.

Answers to the following questions are for our records and will be considered confidential.

YES NO Are you in good health?
YES NO Has there been any change in your general health within the past year?
YES NO Are you pregnant? (Women)
YES NO Are you nursing? (Women)
YES NO Have you ever had any major medical operations?_____
YES NO Are you now under the care of a Physician?
If so, what is the condition being treated?_____
YES NO Have you had any serious trouble associated with previous dental treatment?_____
YES NO Have you ever had an excessive amount of bleeding following tooth extraction?_____
YES NO Have you received any donor organs, artificial heart valves, vessels, joint implants (knee or hip replacement)?
YES NO Do you have any disabilities (physicial or mental impairments), record of impairment or are you regarded as being disabled?
If so, explain_____
YES NO Do you wear a pacemaker?

Do you have or have you had any of the following diseases or problems?

YES NO Congenital heart lesions?
YES NO Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke, high blood pressure)? (Please circle specific problem)
YES NO Hepatitis, jaundice or liver disease?
YES NO Cancer?
YES NO Tuberculosis?
YES NO Diabetes?

MORE QUESTIONS ON THE REVERSE SIDE OF THIS PAGE, PLEASE TURN PAPER OVER.

YES NO Fainting spells or seizures?
YES NO Kidney trouble?
YES NO Stomach ulcers?
YES NO Persistent cough or cough up blood?
YES NO Allergy (to any food, medicine, chemical or material)?
YES NO Asthma or hay fever?
YES NO High blood pressure?
YES NO Low blood pressure?
YES NO Blood disorders such as anemia?
YES NO Have you had surgery or x-ray treatment for a tumor, growth or other conditions of your mouth or lips?
YES NO Have you tested positive for HIV or been told you have the HIV virus?
YES NO Do you have AIDS or other immunosuppressive disorders?

Are you allergic or have you reacted adversely to:

YES NO Penicillin, Amoxicillin, Sulfa or other antibiotics?
YES NO Iodine?
YES NO Aspirin, Ibuprofen, Codeine, Hydrocodone or other pain killers?
YES NO Local anesthetics (example, Novocaine or Lidocaine)?
YES NO Latex Allergy?
YES NO Other drugs or medications (name of drug you had problems with):_____

Are you taking any of the following:

YES NO Steroids (Cortisone, Prednisone)?
YES NO Nitroglycerine, Digitalis, Beta Blocker or other heart medicine?
YES NO Insulin, tolbutamide (Orinase) or similar drug?
YES NO Anticoagulants (blood thinners)?_____

Do you have any disease, conditions or problems not listed above that you think I should know about? If so please explain_____

_____

Date of last physical:_____Name of Physician who administered exam_____

Please list all medications (prescription and non-prescription) that you are taking_____

_____

_____

_____

PLEASE INFORM US OF ANY CHANGES IN YOUR MEDICAL HISTORY

ALL SERVICES MUST BE PAID FOR WHEN RENDERED. ANY OTHER ARRANGEMENTS MUST BE MADE IN ADVANCE.

SIGNATURE ON FILE

The information I have given 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 staff responsible for any errors or omissions that I have made in the completion of this form. I authorize use of this form on all my insurance submissions and release of information to all my insurance companies. I authorize payment directly to my dentist unless payment has been made by me. I understand responsibility for payment is mine and is payable at the time services are rendered. I further understand all attorney fees, court costs and collection service fees incurred in the collection of this account are my responsibility. I permit a copy of this authorization to be used in place of the original.

_____ _____

(Signature of Patient or Legal Guardian) (Date)

If someone other than the patient is completing this form, please give your name and relationship to patient._____

_____