Allyson A. Abbott, DMD ● CHRISTIAN J. LEHR, DMD ● TINA CHOU, DMD

●●●●●● PATIENT REGISTRATION/UPDATE FORM ●●●●●●

THIS FORM MUST BE COMPLETED AND SIGNED PRIOR TO YOUR APPOINTMENT

PATIENT INFORMATION

NAME_____

ADDRESS_____

CITY_____STATE_____ ZIP_____

HOME PHONE_____

WORK PHONE_____

CELL PHONE_____

BIRTH DATE_____

EMAIL_____

SPOUSE'S NAME_____

BIRTHDATE_____

CELL PHONE_____

WORK PHONE_____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

NAME_____
DOB_____SOC.SEC.#_____

ADDRESS_____
CITY_____STATE_____ZIP_____

PHONE #_____

SIGNATURE/DATE_____

PRIMARY DENTAL INSURANCE INFO

INSURANCE CO._____

POLICY HOLDER NAME_____

SOC. SEC. #_____ DOB_____

EMPLOYER_____

GROUP #_____

POLICY/ENROLLEE ID#_____

INS CO ADDRESS_____

_____

INS CO PHONE #_____

SECONDARY DENTAL INSURANCE INFO

INSURANCE CO._____

POLICY HOLDER NAME_____

SOC. SEC. #_____ DOB_____

EMPLOYER_____

GROUP #_____

POLICY/ENROLLEE ID#_____

INS CO ADDRESS_____

_____

INS CO PHONE #_____

EMERGENCY CONTACT (NAME, RELATIONSHIP, PHONE NUMBER)

_____

WHOM MAY WE THANK FOR THIS REFERRAL?

_____

WHO IS YOUR GENERAL DENTIST?

_____

I hereby authorize Allyson A. Abbott, DMD, Christian J. Lehr, DMD, Tina Chou, DMD to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I agree to accept full financial responsibility for services rendered including those services not covered by my dental insurance carrier or services that are only partially covered.

_____

_____

PATIENT SIGNATURE (PARENT OR GUARDIAN IF MINOR) **DATE**

MEDICAL HISTORY

Patient Name:_____

ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN? YES NO

PHYSICIAN'S NAME_____

PHYSICIAN'S ADDRESS_____

PHYSICIAN'S PHONE #_____

HAVE YOU TAKEN ANY BONE SUPPORT MEDICATION? YES NO

HAS TEHRE BEEN ANY CHANGE IN YOUR HEALTH IN THE PAST YEAR YES NO

PLEASE LIST ALL MEDICATION OR DRUGS YOU ARE TAKING PRESENTLY:

MEDICATION	DOSAGE	FOR WHAT REASON

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

RHEUMATIC FEVER	YES	NO	LIVER DISEASE(HEPATITIS/JAUNDICE)	YES	NO
HEART MURMUR	YES	NO	KIDNEY DISEASE	YES	NO
HYPOGLYCEMIA	YES	NO	TUBERCULOSIS	YES	NO
MITRAL VALVE PROLAPSE	YES	NO	HEMOPHILIA/BLEEDING	YES	NO
CONGENITAL HEART DEFECT	YES	NO	ANEMIA	YES	NO
HIGH/LOW BLOOD PRESSURE	YES	NO	CONVULSIONS/EPILEPSY	YES	NO
HEART ATTACK/CORONARY	YES	NO	VENEREAL DISEASE	YES	NO
ANGINA	YES	NO	HERPES VIRUS	YES	NO
HEART SURGERY	YES	NO	ARTIFICIAL JOINTS	YES	NO
STROKE	YES	NO	DATE:_____		
PSYCHIATRIC TREATMENT	YES	NO	PACEMAKER	YES	NO
PNEUMOTHORAX	YES	NO	ARTIFICIAL HEART VALVES	YES	NO
RESPIRATORY DISEASE	YES	NO	RADIATION TREATMENT	YES	NO
ASTHMA	YES	NO	EXCESSIVE BLEEDING		
DIABETES	YES	NO	FROM CUT OR EXTRACTION	YES	NO
ULCERS	YES	NO	NEUROLOGICAL DISORDERS	YES	NO
HIV POSITIVE	YES	NO	ARE YOU PREGNANT?	YES	NO
STATUS_____			HAVE YOU EVER TAKEN PHEN-FEN	YES	NO
GLAUCOMA	YES	NO			

ARE YOU ALERGIC TO OR HAVE YOU BEEN TOLD NOT TO TAKE ANY OF THE FOLLOWING? (PLEASE CHECK)

____PENICILLIN ____CODEINE ____ASPIRIN

____NOVOCAINE ____SULFA ____OTHER_____

ARE THERE ANY MEDICAL CONDITIONS NOT STATE ON THIS FORM THAT THE DOCTOR SHOULD BE MADE AWARE OF PRIOR TO DENTAL TREATMENT, IF YES PLEASE EXPLAIN:_____

_____

To the best of my knowledge the above information is accurate.

_____ _____ _____

Patient's Signature **Date** **Doctor's Signature**