PATIENT REGISTRATION

ID: ______ Chart ID: ______

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ______

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: ______ Address 2: ______

City: ______ State / Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ______ Age: ______ Soc Sec: ______ Drivers Lic: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: ______ Pref. Dentist: ______

Employer ID: ______ Pref. Pharmacy: ______

Carrier ID: ______ Pref. Hyg: ______

Section 3

Referred By: ______

Emegency Contact: ______

Emergency # ______

Primary Dr. ______

Primary Dr. # ______

Primary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2: ______

City, State, Zip: ______

Ins. Company: ______

Address: ______

Address 2: ______

City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

Secondary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2: ______

City, State, Zip: ______

Ins. Company: ______

Address: ______

Address 2: ______

City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

R. Lee Warren, DDS, PA

Warren General Dentistry

Patient Name: Birth Date: Date Created:

Please complete all sections, use "None" or "NA" where applicable.

Patient Allergies

Are you allergic to any of the following?

- [ ] Aspirin
- [ ] Penicillin
- [ ] Codeine
- [ ] Sulfa Drugs
- [ ] Metal
- [ ] Latex
- [ ] Acrylic
- [ ] Local Anesthesia
- [ ] Hydrocodone

Other? ☐ If yes

Question	Answer	If yes
Are you currently taking any medications? (please list)	○ Yes ○ No	If yes
Are you currently under the care of a physician? If so, who and why?	○ Yes ○ No	If yes
Please list any hospitalizations and previous surgeries.	○ Yes ○ No	If yes
Are you taking or have your ever taken a Bisphosphonate drug to strengthen bones? (Ex: Fosamax, Boniva, Reclast)	○ Yes ○ No	If yes
Are you taking any of the following? (Please circle) Blood Thinners, Insulin, Nitroglucerin, or Recreational Drugs?	○ Yes ○ No	If yes
Do you have TMJ problems: popping, clicking, pain, or locking of jaw joints?	○ Yes ○ No	If yes
Have you had a bone or joint replacement? If yes, when and what bone or joint?	○ Yes ○ No	If yes
Have you traveled outside of the country in the last 30 days or been exposed to someone who has?	○ Yes ○ No	If yes

Have you ever had or do you have: (Circle YES or NO for each)

Condition		Condition		Condition	
Fainting Spells	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Fever Blisters	○ Yes ○ No
Seizures or Epilepsy	○ Yes ○ No	Chest Pain or Angina	○ Yes ○ No	Mental Health Disorder	○ Yes ○ No
Prolonged Bleeding	○ Yes ○ No	Heart Attack	○ Yes ○ No	Stroke	○ Yes ○ No
Organ Transplant	○ Yes ○ No	Heart Disease	○ Yes ○ No	Diabetes	○ Yes ○ No
Recent Hoarseness	○ Yes ○ No	Heart Valve Problem	○ Yes ○ No	Hepatitis/Liver Disease	○ Yes ○ No
Difficulty Swallowing	○ Yes ○ No	Heart Valve Replacement	○ Yes ○ No	Tuberculosis (TB)	○ Yes ○ No
Shortness of Breath	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Stomach Ulcers	○ Yes ○ No
Morning Cough	○ Yes ○ No	Atrial Fibrillation	○ Yes ○ No	Cancer	○ Yes ○ No
Sinus Trouble	○ Yes ○ No	Congestive Heart Failure	○ Yes ○ No	Radiation Treatment	○ Yes ○ No
Asthma or Lung Disease	○ Yes ○ No	Thyroid Problems	○ Yes ○ No	Reaction to Anesthesia	○ Yes ○ No
Anemia/Lukemia	○ Yes ○ No	HIV/AIDS	○ Yes ○ No	Shingles	○ Yes ○ No
Blood Disorders	○ Yes ○ No	Herpes	○ Yes ○ No	Tobacco Products	○ Yes ○ No
Kidney Problems	○ Yes ○ No				

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

FEMALES:

Are you pregnant or possibly pregnant? If yes, how many weeks? ○ Yes ○ No If yes

The above information is complete and accurate to the best of my knowledge. I understand providing incorrect information can be dangerous to my (or patient's) health. It is my responsilbility to in

Signature of Patient, Parent or Guardian

X Date: