

Welcome and thank you for choosing our office.

PATIENT REGISTRATION FORM (FOR MINOR)

(To be filled out by parent or legal guardian)

Patient's Last Name _____ First _____ MI _____ Mr. Miss

Patient prefers to be called: _____ Home Phone _____ Birth Date _____ Age _____

Mailing Address _____ City _____ Zip _____ How Long? _____

Father's Name _____ Social Security No. _____

Employer _____ Occupation _____ Bus. Phone _____

Mother's Name _____ Social Security No. _____

Employer _____ Occupation _____ Bus. Phone _____

Nearest relative not living with you _____ Phone _____

Billing address if different than patient's _____

Has any member of your family been treated in this office? Yes No Who? _____

Whom may we thank for referring you? _____
(Please check one) Family Friend Location Yellow Pages Website Other _____

I understand and agree that (regardless of my insurance status) I am responsible for the balance on this account for any professional services rendered by Barry C. Willis, D.D.S. Whether the minor is accompanied by a parent or not, payment is due and expected at the time of service. If obligations remain unpaid past the date of service, I agree that late payment charges (and collection expenses in the event of default) can be added to the unpaid balance. I authorize this office to obtain information concerning any statements made herein and understand that this may include a credit bureau report. I authorize release of personal health information, including x-rays, for purposes of treatment.

I will be paying today by "*****ECTGETGF K" Cash "*****Fkæqxgt" VISA / MC Check (in state bank with Drivers License only)

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____ **DATE** _____

FOR PATIENTS WITH DENTAL INSURANCE

Acceptance of your dental insurance by our office is not a guarantee that your company will pay its insurance co-payment. Your company may pay some, all or none of the insurance estimate. The undersigned party is liable for financial payment and is responsible for the entire treatment fee. If we accept assignment of benefits, you must pay your deductible and co-payment at the time of service. Any remaining balance must be paid by you within 45 days from the initial claim date or within ten days of company settlement, whichever is sooner. Any reimbursement by your company after this date will be refunded to you through our office. I agree that late payment charges and collection expenses in the event of default may be added to the balance. I authorize the release of any information relating to any insurance claim with this office. I authorize payment of the dental benefits otherwise payable to me directly to Barry C. Willis, D.D.S. I permit a copy of this authorization to be used in place of the original.

Insured Employee's Name _____ Insurance ID No. _____

Employer _____ Birth Date _____

Name of Plan _____ Group No. _____

Spouse's Name of Insurance Plan if Applicable _____ Plan No. _____ Birth Date _____

Employer _____ Social Security No. _____

HEALTH QUESTIONNAIRE

Please answer each question. Check yes or no where applicable.

MEDICAL HISTORY

FOR OFFICE USE ONLY

Date / /
Signature _____

Date / /
Signature _____

Date / /
Signature _____

1. Are you in good health? yes no
2. Date of last physical examination? _____
3. Are you now under the care of a physician?..... yes no
If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? yes no
5. Have you ever been hospitalized?..... yes no
If so, what was the problem? _____
6. Are you taking any drugs or medicine?..... yes no
If so, what? _____
7. Are you sensitive or allergic to any drugs, metals, etc? yes no

8. Do you have, or have you had any of the following: (check if yes – leave blank if no)

If so, what? _____ Latex Nickel Codeine Aspirin Penicillin Antibiotics

Allergies	Heart Ailments, Murmurs	Respiratory Disease	Fainting Spells
Anemia	Osteoporosis / osteopenia	Fibromyalgia	Chest Pain
Asthma or Hay Fever	Hepatitis, Jaundice or Liver Disease	Sinus Trouble	Thyroid
Blood Diseases	High Blood Pressure	Stroke –When? _____	AIDS/HIV
Cancer	Kidney Disease	Stomach Ulcers	Blood Transfusion
Diabetes	Low Blood Pressure	Tuberculosis	Immune System Disorder
Epilepsy or Seizures	Mental or Nervous Disorders	Tumors or Growths	Frequent Heada
Excessive Bleeding	Head Injuries	Venereal Disease	Drug/Alcohol Problems
Heart Attack _____	Radiation Treatment of any kind	Arthritis	Prosthetic Joints

9. Have you used “bone builder” medicines for osteoporosis? yes no (9a.) Do you wear a pacemaker? yes no
10. Have you had heart surgery?..... yes no (10a.) Do you take blood thinners such as coumadin or plavix ? yes no
11. Do you have any diseases, conditions, or problems not listed that we should know about?..... yes no
If so, explain _____
12. (Women) Are you pregnant or nursing? yes no ? Birth Control Pills/Hormones ? yes no

DENTAL HISTORY

- Dental complaint at this moment? _____
13. Have you ever had any jaw-joint pain, noise, popping, clicking, or locking? Any history of jaw-joint injury yes no
 14. Have you ever had any unfavorable reaction from a local anesthetic? (Novocaine, Lidocaine, etc.)..... yes no
 15. Have you had any serious problems associated with any previous dental treatment?..... yes no
If so, explain _____
 16. Does dental treatment make you nervous?..... yes no
If yes, check: Slight Moderate Extremely What in particular? _____
 17. How long has it been since you have had dental x-rays of your entire mouth? _____
 18. How long since your last dental treatment? ____/____/____ Date of last cleaning? ____/____/____
 19. Have you ever had excessive bleeding after dental treatment that required treatment?..... yes no
 20. Do you prefer to maintain healthy teeth and gums? yes no unsure ? 21. Do your gums bleed? yes no
 22. Have you ever had gum disease or gum surgery? yes no 23. Do you like the appearance of your smile? yes no

Former Dentist _____	City _____	Phone _____
Name of Physician _____	City _____	Phone _____
Additional Health Information _____		

I hereby authorize Dr. Barry C. Willis to perform such dental operations or procedures, and to administer anesthesia, medications, sedatives, and nitrous oxide as may be deemed necessary or advisable in the diagnosis and treatment of the above named patient.

CONSENT FOR TREATMENT:

SIGNATURE _____ **Date** _____

Authorization must be signed by the patient or by the legal guardian in the case of a minor or when the patient is physically or mentally impaired.