SANGER DENTAL
AT·THE·BASIN

REGISTRATION FORM Today's Date:

PATIENT INFORMATION

Full Name: Preferred Name:	Birth date:	Marital Status:	Sex: M F (circle one)
Address:	City:	State:	Zip:

Home Phone no.:	Work Phone no.:	Cell Phone no.:	Cell Phone Carrier: circle one Verizon AT&T Sprint T-Mobile Other:
Occupation:	Employer/ School:	Social Security no.:	Email:

Previous Dentist:

How did you hear about us?	Other family members seen here:

DENTAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:			Home phone no.:
Is this person a patient here?	Yes No (circle one)	Is this patient covered by insurance?	Yes No (circle one)

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Insurance ID no.:	Group no.:

Subscriber's Employer: Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Insurance ID no.:	Group no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of contact: Relationship to patient: Phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Sanger Dental at the Basin. I understand that I am financially responsible for any balance. I also authorize Sanger Dental at the Basin or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

PATIENT HEALTH HISTORY INFORMATION

17.0

Date: | Patient Name (Last, First, MI): | Birth Date (MM/DD/YYYY)

ALLERGIES - Select all that apply:

- ☐ Aspirin Allergy
- ☐ Codeine Allergy
- ☐ Erythromycin Allergy
- ☐ Hay Fever
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Other Allergy:

MEDICATIONS - Please list any medications you are currently taking including vitamins and dietary supplements

☐ Please check this box if your physician or previous dentist recommended you take antibiotics prior to your dental treatment.

Medical Conditions - Please check box if you have had any of the following:

17.0

- ☐ Angina
- ☐ Artifical Heart Valve
- ☐ Congenital Heart Defect
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Heart Attack - If so when?
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Other Heart Problems
- ☐ Stents
- ☐ Stroke If so, when?

- ☐ Acid Reflux
- ☐ Gastrointestinal Disease
- ☐ GERD
- ☐ Ulcers (stomach)

- ☐ Aspergers
- ☐ Autism
- ☐ Epilepsy / Seizure
- ☐ Intellectual Disability
- ☐ Nervous Disorder

Hepatitis ☐ A ☐ B ☐ C

- ☐ Jaundice
- ☐ Liver Disease
- ☐ Cirrhosis
- ☐ Kidney Disease

- ☐ Cancer: List type
- ☐ Chemotherapy - If so, when?
- ☐ Radiation - If so, when?

- ☐ Anemia
- ☐ Blood Disorders
- ☐ Leukemia
- ☐ Hemophilia

- ☐ Asthma
- ☐ Use Inhaler
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Mouth Breathing
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Snoring at night
- ☐ Tuberculosis

- ☐ AIDS
- ☐ Herpes
- ☐ HIV Positive
- ☐ HPV
- ☐ Sexually Trans Disease

- ☐ Detached Retina
- ☐ Dizzy Spells/Fainting
- ☐ Glaucoma
- ☐ Nursing
- ☐ Pregnant

Due Date

- ☐ Tumors

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Cerebral Palsy
- ☐ Osteoporosis
- ☐ Rheumatism

- ☐ Diabetes
- ☐ Thyroid Disease

List any other condition you may have

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I acknowledge that I have answered the above questions correctly and to the best of my ability, and that any questions that I had have been answered to my satisfaction. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

I authorize Sanger Dental at the Basin to use and disclose my health information about for treatment, payment, and healthcare operations. (Notice of HIPPA privacy practices available upon request).

_____ _____

Patient or Legal Guardian Signature Relationship to Patient