PATIENT REGISTRATION AND MEDICAL HISTORY
(PLEASE PRINT)

DATE _____

PATIENT _____
Last Name First Name MI

ADDRESS _____
Street City State Zip

HOME #: _____ CELL #: _____WORK #: _____

SEX: ☐M ☐F AGE: _____ BIRTHDATE: _____ ☐Single ☐Married ☐Child

Employer:_____ Occupation: _____

Email: _____ Student: Full Time Part Time

Social Security #: _____ Spouse/Parent Social Security #: _____

Spouse/Parent Name: _____ Spouse/Parent Birthdate: _____

Spouse/Parent Employer: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

Person Responsible for this Account: ☐SELF ☐SPOUSE ☐PARENT ☐GUARDIAN ☐OTHER

Dental Insurance: _____ Group #: _____

Emergency Contact: _____ Phone #: _____

How did you hear about us? ☐Internet ☐Health Fair ☐Other, please explain_____

☐Referred, whom may we thank for referring you? _____

Reason for Today's Visit: _____ Date of last dental visit: _____

Dentist's Name: _____ What was done: _____

Medical History

Do you have or have you ever had any of the following? (check all that apply)

☐Heart Problems	☐Epilepsy	☐Special Diet	☐Stroke
☐High Blood Pressure	☐Headaches/Migranes	☐Swollen Neck Glands	☐Ulcer
☐Low Blood Pressure	☐Hepatitis, jaundice or liver disease	☐Rheumatic Fever	☐Diabetes
☐Circulatory Problems	☐Immunosuppressive Disorder	☐Sinus Problems	
☐Cancer			
☐Nervous Problems	☐Artificial Heart Valves/Joints	☐Radiation Treatment	☐Arthritis
☐Weight Loss	☐Psychiatric Care	☐Chronic Diarrhea	☐Hemophilia
☐Back Problems	☐Respiratory disease/asthma	☐Allergies	☐Smoker
☐Chemical Dependency	☐Venereal disease	☐HIV	

Do you have any drug allergies or have you had an adverse reaction to any medication? _____ if yes, to what _____

Have you responded negatively to medical or dental treatment? _____

Are you taking any medications at this time? _____ if yes, what? _____

Are you currently under the care of a physician? _____

Physician's Name: _____ Physician phone #: _____

Date of Last Physical:_____

f yes, for what condition(s)?_____

Are you Pregnant? ☐YES ☐NO Due Date _____ Nursing? ☐YES ☐NO Birth Control? ☐YES ☐NO

Is there anything else we should know about your medical/dental history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in the treatment, billing, and processing of insurance for benefits for which myself or my child is entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____

Relationship to patient (if patient is a minor): _____

Minor/Child Consent

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays and the administration of anesthetics which are deemed advisable by the doctors at Tulane Family Dentistry, whether or not I am present at the appointment when the treatment is rendered.

Date: _____ Signature of Parent/Guardian: _____

Authorization

General Consent to Treatment: I agree and consent to a dental examination by the doctors at Tulane Family Dentistry. I understand that additional diagnostic procedures and treatment may be recommended by the dentist and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment.

Release of Information: I authorize dentists providing services on behalf of the patient to release all billing and medical information to patient's insurance carrier, employer, person(s) acting on behalf of a preferred provider arrangement or a third party named on the patient information form, when such information is requested. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this office. A copy of our privacy practices has been provided to you and details your protected health information rights.

Assignment of Insurance of Third Party Coverage: I authorize any third party payer to pay directly to the dentist providing services to the patient. All benefits due are due payable as a result of services rendered.

I authorize assignment to the dentist providing services to the patient that the insured's rights to penalties and attorney's fees in the event that the insurer fails to timely pay such benefits in accordance with Louisiana Law (LA R.S. 22:657)

Acknowledgement of Responsibility to Pay for Services: I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payer. I acknowledge that this fee is incurred on an open account for professional dental services, in accordance with R.S. 9:2781. I acknowledge that if I fail to pay the balance due on this open account within thirty days after written demand, and in the event judgment is rendered against me, in addition to the principal balance due, I shall be liable for reasonable attorney fees, legal interest from date of judicial demand, until paid, plus costs of court.

_____

Signature of Patient, Parent/Guardian

_____

Relationship to Patient (if child is a minor)

_____

Date