Morrison Dental Group
FAMILY OWNED AND OPERATED
EST
1992

PATIENT INFORMATION:

Patient Registration Form

Date:____________________

I was referred to this practice by: ____

Chart#:______________________________ Email for Appointment Reminders: ______________________

Last Name:______________________________ First Name:______________________ Middle Initial: ____________

Street Address:____________________________ Apt#:__________ City:______________ State:________ Zip: __________

Mailing Address (If Different): ________________________ Apt#:______ City: __________ State:_______ Zip: __________

SS#:__________________ Home Phone:________________ Work Phone:________________ Cell:________________

Sex: Male ☐ Female ☐ Marital Status: S ☐ M ☐ D ☐ W ☐ Date of Birth:_____________ Age: _________

Occupation:______________________________ If Student, School: ______________________________

Employer:______________________ Address:______________________________ Phone:____________________

Spouse's Name____________________ Employer: ____________________ Spouse SS#: ____________________

Emergency Contact (Name): ______________________________ Emergency Contact Phone: ____________________

Preferred contact method for appointment reminders? (check all that apply): Text me! ☐ Call me! ☐ Email me! ☐

RESPONSIBLE PARTY (if different from the patient):

Last Name:______________________________ First Name:______________________ Middle Initial: ____________

Address:______________________________ Apt#:__________ City:______________ State:________ Zip: __________

SS#:_____________ Date of Birth:_____________ Relationship to Patient: Spouse ☐ Parent ☐ Other ☐ __________

Home Phone:__________________ Work Phone:____________________ Occupation: ____________________________

Employer:______________________ Address:______________________________ Phone:____________________

PRIMARY DENTAL INSURANCE INFORMATION:

Insurance Company Name:______________________________________ Phone#: ____________________

Claims Address: ____

Policy ID#:________________________________ Group#:__________________ Plan#: ____________________

Policyholder's Name:____ SS#: ____________________

Insurance Subscriber's Mailing Address (if different from patient):______________________________

Date of Birth:____________________ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ _________

Employer:______________________ Address:______________________________ Phone:____________________

SECONDARY INSURANCE INFORMATION (DENTAL):

Insurance Company Name:______________________________________ Phone#: ____________________

Claims Address: ____

Policy ID#:________________________________ Group#:__________________ Plan#: ____________________

Policyholder's Name:____ SS#: ____________________

Insurance Subscriber Mailing Address (if different than above): ______________________________

Date of Birth:____________________ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ _________

Employer:______________________ Address:______________________________ Phone:____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

-You May Refuse to Sign This Acknowledgement-

I,____, have reviewed a copy of this office's Notice of Privacy Practices.

MEDICAL HISTORY

Physician's Name____ Date of Last Physical ____________________

Have you ever had any of the following? (Check boxes that apply):

- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Latex Allergy
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Alzheimers
- ☐ Dementia
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Mitral Valve Prolapse
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Blood Thinners
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ AIDS/HIV
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ____________________

If so, what? ____

Have you ever responded adversely to medical or dental treatment? ____

Are you taking any medication at this time?__________________ If so, what? __________________________________

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? ____

If patient is a child, what is his/her weight? ____

(Woman) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? ____

Have you had any x-ray's in the last 5 years at another dental practice? ☐ Yes ☐ No

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am 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 ____