



# Wylie Dental

A s s o c i a t e s

## PATIENT REGISTRATION

Patient

Insured or Person  
Financially Responsible for Account

DATE			NAME		BIRTHDATE	
LAST NAME		FIRST	M.I.	RELATIONSHIP TO PATIENT		SOCIAL SECURITY NO.
PREFERS TO BE CALLED BY				ADDRESS		
ADDRESS				CITY	STATE	ZIP
CITY		STATE	ZIP	HOME PHONE NO.	WORK NO.	
HOME PHONE NO.		WORK NO.		CELL	EMAIL	
CELL		EMAIL		PERSON TO CONTACT FOR EMERGENCY		
BIRTHDATE	AGE	MALE	FEMALE	HOME PHONE NO.	WORK NO.	
SOCIAL SECURITY NO.				CELL	EMAIL	

MARRIED     SINGLE     CHILD     OTHER

## MEDICAL HISTORY

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers.....	Yes	No	Hepatitis A	B	C (circle)....	Yes	No
Congenital Heart Disease.....	Yes	No	Diabetes.....	Yes	No	H.I.V. Positive .....			Yes	No
Heart Murmur .....	Yes	No	Thyroid Problems.....	Yes	No	A.I.D.S. ....			Yes	No
High Blood Pressure.....	Yes	No	Glaucoma .....	Yes	No	Cold Sores/Fever Blister .....			Yes	No
Mitral Valve Prolapse.....	Yes	No	Tobacco Smoke/Dip.....	Yes	No	Blood Transfusion .....			Yes	No
Artificial Heart Valve .....	Yes	No	Emphysema.....	Yes	No	Hemophilia .....			Yes	No
Heart Pacemaker.....	Yes	No	Tuberculosis .....	Yes	No	Sickle Cell Disease .....			Yes	No
Rheumatic Fever .....	Yes	No	Asthma.....	Yes	No	Liver Disease.....			Yes	No
Arthritis/Rheumatism .....	Yes	No	Blood Thinners.....	Yes	No	Yellow Jaundice.....			Yes	No
Cortisone Medicine.....	Yes	No	Latex Sensitivity.....	Yes	No	Neurological Disorders .....			Yes	No
Fen-Phen.....	Yes	No	Allergies or Hives.....	Yes	No	Epilepsy or Seizures .....			Yes	No
Stroke .....	Yes	No	Fosamax.....	Yes	No	Fainting or Dizzy Spells.....			Yes	No
Artificial Joints (hip, knee, etc.)...Yes	No		Radiation/Chemotherapy.....	Yes	No	Nervous/Anxious .....			Yes	No
Kidney Trouble.....	Yes	No	Tumors.....	Yes	No	Psychiatric/Psychological Care ....			Yes	No

Are you taking any medication or drugs currently, including regular doses of aspirin over-the-counter herbal medicines? ..... Yes No

If yes, please list name and dosage \_\_\_\_\_

Are you aware of having an allergic (or adverse) reaction to any medication or substance? ..... Yes No

If yes, please list \_\_\_\_\_

Do you have or have you had any disease, condition, or problem not listed..... Yes No

If yes, please list \_\_\_\_\_

**Women:** Are you pregnant or think you may be pregnant? Yes \_\_\_ Months No      **Nursing?** Yes No

**Women:** Do you use birth control medications? ..... Yes No

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_