KErin Oral Care

REGISTRATION FORM

SECTION 1: PATIENT INFORMATION DATE:_____

Name: _____Preferred name:_____

Mailing Address:_____Parish:_____Zip_____

Telephone: (H)_____(W)_____(C)_____
The best time to contact me is: ◇A.M. ◇P.M. at ◇Home ◇Work ◇Cell

E-mail address:_____ Date of Birth:_____
mm/dd/yyyy

Employer:_____ If student, school_____

Spouse or Parent's Name_____ Referred by:_____

Emergency Contact Person:_____ Relationship_____

SECTION 2: RESPONSIBLE PARTY

Relationship to Patient: ◇Self ◇ Spouse ◇Parent ◇Other Relationship: _____

Name: _____ Telephone:_____

Mailing Address: _____Parish:_____ Zip_____

Employer: _____ Work no.:_____ E-mail_____

SECTION 3: INSURANCE INFORMATION

Name of Insured:_____ DOB_____ Relationship to Patient_____

Name of Employer:_____ Work no.:_____

Insured Address: _____ Parish:_____ Zip:_____

Insurance Company _____ Group #:_____ ID#_____

Certificate #:_____

Do you have additional insurance information? ◇YES ◇NO If yes, complete below

Name of Insured:_____ DOB_____ Relationship to Patient_____

Name of Employer:_____ Work no.:_____

Insured Address: _____ Parish:_____ Zip:_____

Insurance Company _____ Group #:_____ ID#_____

Certificate #:_____

PROCEED TO OTHER SIDE ➡

SECTION 4 MEDICAL & DENTAL HEALTH HISTORY

Please answer ALL questions to assist us in better treating you!

A. DENTAL

Have you seen a dentist in the last 2 years? ◇Yes ◇No

What type of dental work have you had completed? ◇Fillings ◇Extractions ◇Crowns/Bridges ◇Implants ◇Dentures ◇Other _____

Do you have access to your dental records? ◇Yes ◇No If yes, name of company_____

What is your reason for seeking treatment in our office? _____

_____

_____

B. MEDICAL

Have you been treated in a hospital in the past 2 years? ◇Yes ◇No If yes, why?

_____

_____

Have you been under the care of a physician during the past 2 years? ◇Yes ◇No If yes, why?

_____

Have you taken ANY kind of medication or drugs in the last 6 months? ◇Yes ◇No If yes, list

_____

Are you ALLERGIC to any medications or drugs? i.e. penicillin, codeine, aspirin, etc ◇Yes ◇No

Have you ever received treatment for excessive bleeding? ◇ Yes ◇ No

Please check ALL of the following conditions which you have had or are receiving treatment:

◇Heart Trouble	◇Congenital Heart Disease	◇Heart Murmur	◇Diabetes
◇Tuberculosis	◇Jaundice	◇Asthma	◇Epilepsy
◇Psychiatric disorder	◇Rheumatic fever	◇Arthritis	◇Stroke
◇High blood pressure	◇Anemia	◇Hepatitis	◇Herpes II
◇Venereal disease	◇Cholesterol	◇Cancer	

Have you been treated for any other serious illness? ◇Yes ◇No If yes, state_____

(WOMEN) Are you pregnant? ◇Yes ◇No

PLEASE NOTE THE FOLLOWING:

***PAYMENT POLICY**: All accounts are expected to be paid in full at time of service. However, any treatment not paid is due within 30 days. Accounts not paid in full are subject to a 5% charge monthly.

***OUTSTANDING ACCOUNTS**: All collection charges on outstanding accounts are the responsibility of the patient.

***INSURANCE POLICY**: As a courtesy to you, our office will submit to your insurance company dental claims on your behalf (provided you inform us of your insurance information and any changes that may occur). In the event that your insurance company **FAILS** to pay the fee for service, the balance due is the responsibility of the patient.

A MEMBER OF THE BERMUDA CREDIT ASSOCIATION

Patient Signature _____ **Date:** _____