Patient Registration & Health Survey

Please print and complete the following information. It will remain confidential.

Date _____

Name _____

Spouse _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Email _____

Birthdate _____ Age _____

Social Security No. _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact _____

Phone Number _____

Referred to us by _____

▪ Child's Appointment ▪

Name _____

Birthdate _____ Age _____

❑ Male ❑ Female

If your child's last name and/or address are not the same as yours, please add this additional information:

Address _____

City _____ State _____ Zip _____

▪ Dental Insurance ▪

Primary Carrier _____

Insurance Company _____

Group No. _____

Employment Information

Date of Birth _____

Occupation _____

Employer _____

Subscriber ID _____

Employee Social Security No. _____

Secondary Carrier

Insurance Company _____

Group No. _____

Employee/Subscriber _____

Date of Birth _____

Subscriber ID. _____

Employee Social Security No. _____

▪ Person Financially Responsible for Account ▪

Name _____

☐ I am responsible

☐ Another person is responsible:

Name _____

Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

▪ Health History ▪

1. Are you having pain or discomfort at this time? ☐ Yes ☐ No
2. Are you currently taking a blood thinner? ☐ Yes ☐ No

   If yes, please list _____

3. Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No
4. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

   Physician's Name _____ Phone No. _____

   Address _____

5. Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No
6. Are you now taking any medication or drugs or pills? ☐ Yes ☐ No

   If yes, please list _____

   _____

7. Are you aware of being allergic to
   or have you ever reacted adversely to any medication or substance? ☐ Yes ☐ No

   If yes, please list _____

   _____

8. For women only

   Are you pregnant? ☐ Yes ☐ No

   Yes, what month? _____

   Are you nursing? ☐ Yes ☐ No

   Are you taking birth control pills? ☐ Yes ☐ No

9. Indicate which of the following you have had or have at present. Mark yes or no for each item.

A.I.D.S	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Arteriosclerosis	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Disease or Attack	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Failure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Heart Surgery	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Hepatitis A (infectious)	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Hepatitis B (serum)	☐ Yes	☐ No			
Cosmetic Surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No			
			Kidney Trouble	☐ Yes	☐ No			

10. Do you have or have you had any disease, condition or problem not listed above? ☐ Yes ☐ No

If yes, please list _____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Consent

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and the use of appropriate medication and therapy indicated for such treatment in connection with (patient's name) _____. I understand using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand all responsibility for payment for dental services provided in this office for myself or my dependents is mine. due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1 1/2% finance charge (18% APR) may be added to my account.

Patient: _____ Date: _____

Witness: _____

Parent or Responsible Party: _____

Relationship to Patient: _____

Please return form to Dr. Austin W. Holmes ▪ 1927 23rd Avenue ▪ Meridian, MS 39301
Email: drholmes@austinwholmesdmd.com

HOLMES
DENTAL CARE