TIME 12:40 PM

DATE 7/11/2017

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

ss: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Austin R. Smith III, D.D.S, P.S.

ACTIVE MED HX(Copy)

Date 7/11/2017

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Are you anxious about dental treatment?	◯ Yes ◯ No	
Are you happy with your smile?	◯ Yes ◯ No	
Do you Pre-med for dental treatment?	◯ Yes ◯ No	
Do you snore?	◯ Yes ◯ No	
Do you feel tired a lot?	◯ Yes ◯ No	
Has anybody observed you quit breathing during your sleep?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	◯ Yes ◯ No	If yes	
Other?	☐	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No
Drug Addiction ◯ Yes ◯ No	Hepatitis B or C or A ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No	Anemia ◯ Yes ◯ No
Easily Winded ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No	Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No
Scarlet Fever ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No
Shingles ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No
Sickle Cell Disease ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No
Sinus Trouble ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No
Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No	Bruise Easily ◯ Yes ◯ No
Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No
Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No
Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No
Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No
Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Convulsions ◯ Yes ◯ No
Heart Trouble/Disease ◯ Yes ◯ No	G.E.R.D. ◯ Yes ◯ No	Sjorgens ◯ Yes ◯ No	Dry Mouth ◯ Yes ◯ No

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Please read and sign our FINANCIAL POLICY.....

- Your investment portion is due at the time of treatment. If you would like an estimate, please ask in advance.
- We accept Cash or Checks, Major Credit Cards and Care Credit.
- Would you like to spread payments over time? Let's talk Care Credit!
- We are happy to submit your dental claims for you.
- While we will strive to help you maximize your insurance benefits, we cannot be held responsible for monitoring your plan limitations and changes.

Treatment and Insurance Authorization:

1. The undersigned hereby authorizes doctor and his auxiliaries to take any diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis and completely treat the patient's dental needs.
2. I also authorize Doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize Doctor to employ such assistance as deemed fit to provide recommended treatment.
3. I understand that it is my responsibility to advise your office of any changes in the information on this form.
4. I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due and authorized the dentist to release any information required to complete dental claims. I authorize that my records can be used by the Doctor if he so determines.
5. In consideration of the service rendered to me or my dependants by this dental office, I am obligated to pay said in accordance with its credit terms and policy.
6. I acknowledge that I am financially responsible for all charges whether or not paid by insurance. If it becomes necessary to effect collections of balance due, the undersigned agrees to pay for cost and expenses, including reasonable attorney fees in Thurston County.
7. I certify that I have read, or had read to me, the contest of this form and do realize the risks and limitations involved.

Responsible Party: Date: