



CRYSTAL SMILE
PATIENT REGISTRATION AND MEDICAL HISTORY

Date Email Address Cell Phone

Patient Last Name First Name Initial Preferred Name
Street Address City State Zip
Sex: M F Age Birthday Single Married Widowed Separated Divorced
Employed by Occupation
Business Address Business Phone
Spouse/Parent Name Spouse Birth date
Spouse/Parent Employed by Occupation
Business Address Business Phone
Who is responsible for this account? Relationship to Patient
Social Security # Spouses Social Security #
Primary Insurance Company Name Group Number
Second Insurance Company Name (If Applicable) Group Number
In case of emergency, who should be notified? Phone
Whom may we thank for referring you?

MEDICAL HISTORY

Physician's Name Date of Last Physical

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

Yes No Yes No Yes No
Heart Problems
Heart Murmur
High/Low Blood Pressure
Cholesterol
Artificial Heart Valves or joints (i.e. knee/hip replacement)
Circulatory Problems
Nervous Problems
Radiation Treatment
Recent Weight Loss
Back Problems
Diabetes
Respiratory Disease/Asthma
Epilepsy
Headaches/Dizziness
Hepatitis A, B, C (circle one)
Jaundice or Liver Disease
Cancer
Chronic Diarrhea
Psychiatric Care
Latex Allergy
Allergies to Anesthetics
Allergies to Medicine or Drugs
General Allergies
Blood Disease
Arthritis
Eating Disorder
Thyroid Problems
Rheumatic Fever
Tuberculosis/Pneumonia
Sinus Problems
"A.I.D.S." or Other Immunosuppressive Disorders
Stroke
Ulcer
Venereal Disease
Chemical Dependency
Hemophilia/Anemia (circle one)

Date of last dental check-up Dentist's Name

Reason for today's visit:

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?

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

PLEASE READ AND SIGN:

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.

There will be a \$60.00 per 1/2 hour charge for appointments cancelled or broken without 48 hours advance notice (No exceptions).

It is agreed that all expenses incurred by our office in enforcing its rights to payment for services rendered, including attorney's fees in the amount of 35% and all other court costs incurred shall be recoverable from the client (patient).

Signature X Date