DARRYL VEIT, DDS & ASSOCIATES FAMILY DENTISTRY

Patient Registration • Medical History • Credit Disclosure

(PLEASE PRINT)

Date ______________________ Home Phone ______________________

Patient ______________________
LAST NAME FIRST NAME MIDDLE INITIAL PREFERRED NAME

Street Address ______________________ City ____________ State ______ Zip ________

Sex ☐M ☐F Age ______ Birthdate ______________ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Who is responsible for this account? ______________ Relationship to patient ______________

Social Security # ______________ Spouse Social Security # ______________

Patient (or Parent) Employed by ______________________

Employer Address ______________ City ____________ Phone ____________

Name of Spouse ______________ Employed by ______________

Employer Address ______________ City ____________ Phone ____________

Dental Insurance Company ______________ Group Number ______________

In case of emergency, who should be notified?______________ Phone Number ______________

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 boxes that apply)

☐Heart problems or murmur
☐High blood pressure
☐Low blood pressure
☐Circulatory problems
☐Nervous problems
☐Radiation treatment
☐Artificial heart valves or joints
☐Recent weight loss
☐Back problems
☐Diabetes
☐Respiratory disease
☐Epilepsy
☐Headaches
☐Hepatitis, jaundice or liver disease
☐Cancer
☐Psychiatric care
☐Chronic diarrhea
☐Allergies to anesthetics
☐Allergies to medicine or drugs
☐General allergies
☐Blood disease
☐Arthritis
☐Latex allergy
☐Special diet
☐Swollen neck glands
☐Rheumatic fever
☐Sinus problems
☐AIDS or other immunosuppressive disorders
☐Stroke
☐Ulcer
☐Venereal disease
☐Chemical dependency
☐Hemophilia

Do you have any allergies or have you ever had an adverse reaction to any medication? ☐Yes ☐No

If so, what? ______________________

Have you ever responded adversely to medical or dental treatment? ______________________

Are you taking any medication at this time? ☐Yes ☐No 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

Is there anything else we should know about your medical history? ______________________

____

CREDIT DISCLOSURE

As a courtesy to you, we do accept assignment of benefit payments from most insurance companies. The amount of your insurance company's payment is determined by the level of coverage purchased by your employer. Please remember that your dental insurance is your responsibility. While we are happy to help you with claims submission, we can make no guarantee about insurance payment. We allow 60 days for your insurance company to make payment. After this time, all inquiries and follow up become your responsibility.

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.

Date ______________________ Signature ______________________

I acknowledge that I have received a notice of privacy practices from Dr. Veit and Associates.

Date ______________________ Signature ______________________