ADULT REGISTRATION

Name _____Preferred Name_____ Date of Birth ____/____/_____

Address_____ City_____ State____ ZIP_____

Soc Sec # _____ - ____ - _____ Home Phone_____ Work Phone _____ Cellular_____

Email_____ Marital Status _____Driver's license # _____

How did you hear about our practice? _____

Best way to contact you for appointment reminders ☐Home ☐Work ☐Cell ☐ Email

Spouse name_____ Soc Sec # _____ - ____ - _____Date of Birth ____/____/_____

Primary Dental Insurance

Policy holder's name_____D.O.B._____Soc Sec#_____-_____-_____

Group Name/Employer_____ID #_____Group #_____

Insurance Company_____Insurance phone number_____

Policy holder's relationship_____

Secondary Dental Insurance

Policy holder's name_____D.O.B._____Soc Sec#_____-_____-_____

Group Name/Employer_____ID #_____Group #_____

Insurance Company_____Insurance phone number_____

Policy holder's relationship_____

Emergency Contacts

In event of Emergency, whom may we contact other then yourself?

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

*********OVER*********

Medical History

Have you ever had any of the following conditions **(please circle)**

Allergy to Antibiotics	Cerebral Palsy	Heart Murmur	Low Blood Pressure
Allergy to Codeine	Convulsions/Epilepsy	Hemophilia/Blood Disorders	Pacemaker
Allergy to Latex	Diabetes	Hepatitis	Respiratory Disease
Allergy to Medications	Emphysema	High Blood Pressure	S.T.D.
Asthma	Handicaps/Disabilities	HIV/AIDS	Sinus Problems
Autism	Hearing/Speech Impairment	Joint Replacement	Thyroid Disease
Cancer (past or present)	Heart Condition	Kidney/Liver Disease	Tuberculosis

If **NONE** are circled please initial here_____ **Premedication** Y ☐ N ☐ if yes, please list _____
Please list all **Medications** that you are currently taking_____
_____
Please list any **Allergies**_____
Other_____
Physician Name_____Phone Number_____

Women Only

Circle yes or no

Are you or could you be pregnant	Yes	No
Are you nursing	Yes	No
Are you taking Birth Control	Yes	No
Are you anticipating becoming pregnant	Yes	No

Date_____Signature_____Staff Intials_____

Comments_____

Date_____Signature_____Staff Intials_____

Comments_____

Date_____Signature_____Staff Intials_____

Comments_____

Date_____Signature_____Staff Intials_____

Comments_____

All information gathered is for the sole purpose of insurance verification and billing. All personal information which Locust Lane Dental requests is held in the strictest confidence.

To the best of my knowledge, I have answered every question completely and accurately.

Patient Signature_____Date_____

*********OVER*********