

# Patient Registration-Insurance and Financial Agreement Form

Associates for Family Dentistry, Ltd.

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Date: \_\_\_\_\_

Patient #: \_\_\_\_\_

## \*\*\*Responsible party

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ Phone (cell) \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Circle marital status:    single    married    separated    widowed

Employer:

Name \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Employer phone \_\_\_\_\_ Ext \_\_\_\_\_

Do you have dental insurance?    Y    N    If yes, complete insurance information form

Name of spouse \_\_\_\_\_ Birthdate \_\_\_\_\_

Spouse employer \_\_\_\_\_ SSN \_\_\_\_\_

Employer address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Employer phone \_\_\_\_\_ Ext \_\_\_\_\_

## \*\*\*Patient information

Name \_\_\_\_\_ circle: male    female

Birthdate \_\_\_\_\_ circle relationship: self    spouse    child    other \_\_\_\_\_

Referred by \_\_\_\_\_

In case of emergency contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime phone number \_\_\_\_\_

I have read the financial agreement attached, and I have received a copy of this financial agreement.

Please give 24 hours notice if you cannot keep an appointment. A charge will be rendered for broken appointments.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Responsible party or authorized member of family)

**Insurance Information Form**

Patient Name \_\_\_\_\_

Patient # \_\_\_\_\_

**\*\*\*Primary Insurance Information\*\*\***

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SSN \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

Employer Name \_\_\_\_\_ Telephone# \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Insurance company name \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Group/Policy # \_\_\_\_\_

**\*\*\*Secondary Insurance Information\*\*\***

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (Cell) \_\_\_\_\_

Employer Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

SSN \_\_\_\_\_ Subscriber # \_\_\_\_\_

Insurance company name \_\_\_\_\_ Telephone# \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Group/Policy # \_\_\_\_\_

**Assignment of Benefits:** I authorize payment directly to the provider named. I also authorize release of any dental information necessary to process any dental claims.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Please have your insurance cards available for us to copy.  
Thank you for your assistance.**

# Medical Information

Name of patient being seen today \_\_\_\_\_ Date: \_\_\_\_\_  
Patient number: \_\_\_\_\_

Your medical doctor's name (not your dentist) and location: \_\_\_\_\_

1. How long since your last dental examination? \_\_\_\_\_  
What was done at that time? \_\_\_\_\_
2. Are you having any problems with your teeth or gums now? \_\_\_\_\_  
If yes, what? \_\_\_\_\_
3. Are you currently under the care of a physician? \_\_\_\_\_  
If yes, for what purpose? \_\_\_\_\_
4. Please list any medications you are presently taking and for what reason: \_\_\_\_\_
5. Have you ever been in the hospital? If yes, for what purpose? \_\_\_\_\_
6. Are you allergic to: \_\_\_ Penicillin \_\_\_ Codeine \_\_\_ Latex \_\_\_ Local anesthetic  
Other medication, please list \_\_\_\_\_
7. Do you frequently feel faint or dizzy? \_\_\_\_\_
8. Are you subject to prolonged bleeding? \_\_\_\_\_
9. Do you wear a pacemaker? \_\_\_\_\_
10. Do you wear glasses or contacts? \_\_\_\_\_
11. Do you smoke or use tobacco products? \_\_\_\_\_
12. Do you have a knee or hip replacement/other prosthesis? \_\_\_\_\_
13. Do you have mitral valve prolapse? \_\_\_ Yes \_\_\_ No
14. Have you ever taken any of the following appetite suppressants: Fenfluramine (Pondimin) or Dexphenfluramine (commonly referred to as fen-phen)? \_\_\_\_\_
15. **Women:** Are you pregnant? \_\_\_\_\_ Due date \_\_\_\_\_
16. Have you ever been treated for osteoporosis? \_\_\_\_\_
17. Have you ever taken Fosamax, Actonel, Aredia, Zometa, Boniva? \_\_\_\_\_
18. Please answer the following if it applies to you:  
Are you undergoing chemotherapy? \_\_\_\_\_  
Are you undergoing radiation? \_\_\_\_\_  
Have you had chemotherapy? \_\_\_\_\_  
Have you had radiation? \_\_\_\_\_

19. Place an 'X' next to any of the following you have or had:

- |                         |                     |                    |   |
|-------------------------|---------------------|--------------------|---|
| ___ High Blood Pressure | ___ Heart Surgery   | ___ Diabetes       | ___ Asthma                                  |
| ___ Low Blood Pressure  | ___ Rheumatic Fever | ___ Kidney Disease | ___ Pneumonia                               |
| ___ Heart Disease       | ___ Liver Disease   | ___ Dialysis       | ___ Tuberculosis                            |
| ___ Heart Murmur        | ___ Hepatitis A     | ___ Ulcer          | ___ Venereal disease                        |
| ___ Anemia              | ___ Hepatitis B     | ___ Acid Reflux    | (syphilis, gonorrhea, genital herpes, etc.) |
| ___ HIV/AIDS            | ___ Hepatitis C     |                    |   |