Patient Registration and Medical History

Patient's Names (Mr., Mrs., Ms, Miss, Dr): _____
(First) (Middle) (Last)

Address: _____ City _____ State _____ Zip Code _____

Social Security # _____ Birth Date: _____ Sex _____ Full Time Student Yes ____ No ____

Telephone (Home) _____ (Cell) _____ (Work) _____ E-Mail Address _____

Employed By _____ Employer's Address _____

Whom can we thank for referring you to my practice: _____

Spouse's Name _____ Birth Date _____ Social Security # _____

Spouse's Employer: _____ Employer's Address _____

Person to notify in case of emergency: Name _____ Phone # _____

**********Dental Insurance Information**********

Insured Is: _____Self _____ Husband _____ Wife _____ Mother _____ Father

Employee's Name _____ Employee's Social Security Number _____

Insurance Co. _____ Group # _____ Employee's Birth Date _____

Insurance Co. Address _____ Insurance Co. Phone # _____

Are you covered by a secondary insurance? _____ Yes _____ No

If yes Name of 2nd Insurance Co. _____ Address _____

2nd insurance phone # _____ Group # _____

Employee name for 2nd insurance _____ Social Security # _____

Employee Date of Birth _____

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Must Complete if Under 18 or a Full Time Student. Responsible Party Information Required.

Mother's name _____ Mother's Social Security # _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Work # _____

Father's name _____ Father's Social Security # _____

Address: _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Work # _____

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There is a $4.00 per month charge for all balances which exceed 60 days.

I authorize payment to Dr. Alexander (where applicable) of any Dental Insurance Benefits otherwise payable to me.

X _____

~Continued on other side~

Medical History

Name of Physician_____ Date of Last Physical _____

Address _____ Phone# _____

Are you currently taking any prescription or over the counter medications? YES ____ NO ____
If yes, name of drug(s):_____
Are you taking blood thinners: If Yes name of drug:_____ No _____
Are you allergic to or have had any reactions to any of the following:
Local Anesthetics (I.E. Novocain) YES ____ NO ____ .
Penicillin or any other Antibiotics YES ____ NO ____.
Codeine .....YES ____ NO ____.
Other: Please list _____

WOMEN ONLY: Do you suspect you may be pregnant? YES ___NO____ Are you nursing?_____
Are you taking Bone Strengthening drugs: If Yes: name of drug _____ No ____

Do you now have or have you ever had any of the following:
(Please check all that apply.)

__ Heart Attack __ Angina __ Cardiac Bypass (DATE(_____)
__ Artificial Heart Valve __High Blood Pressure __ Low Blood Pressure
__Heart Murmur __ Mitral Value Prolapse __ Rheumatic Fever/Heart Disease
__ Stroke __ Hemophilia __ Bleeding Disorder
__ Anemia __ TB or Lung Disease __ Asthma
__ Sinus Trouble __ Glaucoma __ Thyroid Disorder
__ Kidney Disease __ Ulcer __ Hepatitis, Jaundice or Liver Disease
__Arthritis __ Diabetes __ Artificial Joints, type/Date. _____
__ Epilepsy __ Recent Weight Loss __ Cancer, type _____
__Venereal Disease __ Radiation Treatment __ AIDS/HIVor Immunosuppressed

__ Chemical Dependency or Substance Abuse __ Smoker, Packs per day _____

Alcohol consumed, Drinks per day / week ____ Other _____

~ DENTAL HISTORY ~

When was your last dental visit?_____ What brings you in today? _____

Do you now have or have you had any of the following?
(Please check all that apply.)

__ Bleeding, Sore Gums __ Loose Teeth __ Teeth Sensitive to Hot
__ Unpleasant Taste, Bad Breath __ Sensitive to Sweets __ Teeth Sensitive to Cold
__ Burning Tongue or Lips __ Sensitive to Biting __ Swelling or Lumps in Mouth
__ Orthodontics (Braces) __ Food Impaction __ Clicking or Popping Jaw
__ Change in Bite __ Grinding(Bruxism) __ Difficulty Opening or Closing Jaw
__ Biting Lips or Cheeks __ Clenching __ Snoring

The information above is accurate and complete to the best of my knowledge. It is intended only for the use in my treatment, billing and processing insurance benefits for which I am entitled. I will not hold Dr. Alexander nor any member of his staff responsible for any errors or omissions that I may have made in completion of this form.

I authorize the release of information regarding dental history and treatment for the purpose of determining benefits payable and I understand that I am responsible for all fees.

X. _____ DATE:_____
(Patient or Parent/Guardian if under age 18)