



# SHERER DENTAL

## REGISTRATION AND HEALTH HISTORY

Patient's Name \_\_\_\_\_ Home Phone # \_\_\_\_\_

Social Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address \_\_\_\_\_ Business Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Present Position \_\_\_\_\_ How Long \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Best Way to Contact You \_\_\_\_\_ Marital Status \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Present Position \_\_\_\_\_ How Long \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Who will pay this account? \_\_\_\_\_

Name of Your Dental Insurance \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Spouse's Dental Insurance \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Your Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Referred By \_\_\_\_\_ Address \_\_\_\_\_

### Next of Kin or Person to Notify in Case of Emergency

Name \_\_\_\_\_ Relationship to You \_\_\_\_\_

Address of this Person \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

### Please Read and Sign

1. It is my understanding that when an appointment is made I will be there or give twenty-four (24) hours of cancellation.
2. I agree to pay for all services rendered. I agree to pay balance (if any) not covered by my insurance (third party) carrier and for services and expenses required to settle the claim including review activities. I am advised my insurance carrier (third party) may determine the services are not medically necessary and deny payment. If this occurs, I am responsible for any payment in full.
3. I will be responsible for any attorney fees required to collect for the services to which may be added interest at the current legal rate.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_  
(Patient or Next of Kin)

**Please Answer Each of the Following Questions**

<table border="0" style="width:100%;"> <tr> <td style="width:50%;"></td> <td align="center"><b>Yes No</b></td> </tr> <tr> <td>Poor Health.....</td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Recent Illness.....</td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Recent Cough or Cold....</td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Nose Obstruction.....</td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Heart or Chest Pain.....</td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Frequent Swollen Ankles.</td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Facial X-ray Treatment....</td> <td align="center"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Cortisone or ACTH.....</td> <td align="center"><input 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<p>Must you sleep with your head on more than one pillow?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you get shortness of breath after a little exertion?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you ever been put to sleep for an operation?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you been hospitalized within the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you smoke or use tobacco?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you ever been treated for substance abuse?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you ever been treated for osteoporosis?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you ever received premedication before dental treatment?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you pregnant?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you now taking medicine of any kind?..... <input type="checkbox"/> <input type="checkbox"/></p>	<p>If yes, when? _____</p> <p>If yes, what for? _____</p> <p>If yes, for how long? _____</p> <p>If yes, when and for what? _____</p> <p>If yes, for how long? _____</p> <p>If yes, what for? _____</p> <p>If yes, how far along are you? _____</p>																																																																																			

Please list any medications you are currently taking (prescribed or over the counter):

Medication Name	Dose	Reason for Taking

Please list any additional medical problems you have that are not listed above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Date	Services