DAVID PARIS
DENTISTRY

ParisDentistry.com

(PLEASE PRINT)

Patient Registration & Medical History

Today's Date: / / Home Phone: Cell:
Patient Last Name:
Patient First Name: Initial:
Preferred Name:
Street Address:
City:
State, Zip:
Sex: Age: Birthdate: / / Family Status:
Social Security #
Driver's License #
Name of Dental Insurance Company:
Group Number:
Employed By: Occupation:
Business Address:
Business Phone:

Spouse Name:
Spouse Social Security #
Spouse Employed By: Occupation:
Business Address:
Business Phone:
Who is responsible for this account?
Relationship to Patient:

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:

Name of Physician: Phone:

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature: Date: / /
Patient, Parent or Guardian

Health Information

Date of last dental visit: / /
Reason for this visit:

Have you ever had any of the following? Please check all those that apply:

☐ AIDS
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy Due Date:
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ OTHER:

Are you taking any medication at this time? ☐ Yes ☐ No
If so, what:

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ☐ Yes ☐ No
If so, what:

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Referral Information

Whom may we thank for referring you to our practice?

- ☐ Another patient, friend
- ☐ Another patient, relative
- ☐ Dental Office
- ☐ Yellow Pages
- ☐ Newspaper
- ☐ Website
- ☐ School
- ☐ Work
- ☐ Other __________

Name of person or office referring you to our practice: ____________________

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone meat home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature: ________________________________
Patient, Parent or Guardian

Date: ______________ Relationship to Patient: ______________

Signature: ________________________________
Guarantor of Payment/Responsible Party

Date: ______________ Relationship to Patient: ______________