PATIENT REGISTRATION

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Full Name:	Name you wish to be called:
Social Security #:	Date of Birth:
Mailing Address:	Zip Code:
Home Phone # :	Cell Phone #:
Age: Gender: Race:	Email Address:
Employer/School Name:	Work Phone #:
Employer Address:	
Marital Status: S M W D SEP	

INSURANCE INFORMATION

	Primary	Secondary
Subscriber (Legal Name):		
Telephone:		
Relation to patient:		
Date of Birth:		
Social Security #:		
Employer:		
Address:		
City, State:		
Zip Code:		
Employer Phone:		
Insurance Company:		
Subscriber ID#:		
Group #:		
Patient ID (if different)		
Insurance Phone #:		

BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, certify that the insurance information listed above is correct and that all insurance benefits for services rendered are directly assigned to Dr. Thomas Stoddard, D.M.D.. I understand that I am financially responsible for all charges regardless of benefits. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions. Should this account be turned over to a collection agency for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney's fees.

Signature: ______________________ **Date:** ____________

Should an employee be exposed to my blood/body fluid in a way that might allow transmission of infection due to blood borne disease (eg. HIV, Hepatitis, etc.) or other communicable diseases; I consent to provide samples of my blood or body fluid to be tested for evidence of infection. I also understand that Dr. Stoddard and employees are obligated to submit to blood tests for certain infectious diseases (eg. HIV, Hepatitis, etc.) if I am inadvertently exposed to their blood or body fluid during the course of my treatment in the office.

Signature: ______________________ **Date:** ____________

GENERAL HEALTH HISTORY

Are you in good health? If no, explain .... Yes No

Are you under a physician's care now? .... Yes No
If yes, explain:

Name of Physician ______________________ City ____________ Phone ____________

Are you taking any drugs or medications? .... Yes No
If yes, please list:

Are you sensitive or allergic to any drugs? .... Yes No
If yes, please list:

Have you been hospitalized in the past two years? .... Yes No
If yes, please explain:

Do you now have or have you had any of the following?

Condition	Yes / No	Condition	Yes / No
HIV	Yes No	Herpes	Yes No
Allergies	Yes No	Hepatitis	Yes No
Anemia	Yes No	High Blood Pressure	Yes No
Asthma or Hay Fever	Yes No	Kidney Disease	Yes No
Blood Diseases	Yes No	Liver Disease	Yes No
Cancer	Yes No	Radiation Treatment	Yes No
Diabetes	Yes No	Rheumatic Fever	Yes No
Epilepsy	Yes No	Rheumatism or Arthritis	Yes No
Excessive Bleeding	Yes No	Stroke	Yes No
Fainting Spells or Seizures	Yes No	Stomach Ulcers	Yes No
Heart Disease	Yes No	Tuberculosis	Yes No
Heart Murmur	Yes No	Venereal Disease	Yes No

Do you have any artificial joints or heart valves? .... Yes No
Do you have any disease, condition, or problem not listed? .... Yes No
WOMEN: Are you pregnant? If yes, due date .... Yes No
Are you taking birth control pills? .... Yes No

DENTAL HISTORY

Dental Complaint at this moment ______________________________

Date of your last dental treatment ___/___/___ Last Cleaning ___/___/___

Do you grind or clench your teeth?	Yes No	Do your gums bleed?	Yes No
Pain in jaw joint?	Yes No	Cold or Canker Sores?	Yes No
Sore or Sensitive Teeth?	Yes No	Unpleasant taste?	Yes No

The above information is true and I will notify you of any changes.

Signature ______________________________ Date ____________

In case of emergency, contact ______________________ Phone ____________