PLEASE PRINT

Neo Dental Care

PATIENT REGISTRATION

Patient Name _____ Birthdate _____ Age _____
(First) (Middle) (Last) (Preferred)

SS# _____ DL# _____ Employer _____ Work #(___) _____

Marital Status: Single___Married___Divorced___Widowed___Spouses Name: _____ Work #(___) _____

Home Address: _____ Zip _____

Home #: (___) _____ Cell #: (___) _____ E-Mail Address: _____

Responsible for Insurance/Account: _____ Relationship: _____

SSN _____ DOB _____ Home # (___) _____

Home Address (if different): _____ Zip _____

Employer & Address: _____ Work #: (___) _____

Nearest Relative Not Living With You _____ Phone # (___) _____

Who told you about us? _____ Physician: _____

Do you have Dental Insurance? YES/NO With Whom? _____

Do you have secondary insurance? YES/NO With Whom? _____

Are you currently having dental problems? YES/NO What are your concerns? *circle as many as applicable (*Pain Avoidance) (Appearance) (Losing Teeth) (Gum/Periodontal Disease) (Cavities) (Oral Cancer) (Cleaning)(Wasting/Exceeding Dental Ins. Limits) (General Health) (Routine Checkup)

(Other) _____

Circle yes or no to the following questions:

1. Are you presently under the care of a physician? Name?..... YES NO
2. Have you ever had high blood pressure?..... YES NO
3. Has a physician ever said you had heart trouble?..... YES NO
4. Do you have artificial joints?..... YES NO
5. Have you ever had abnormal bleeding following a cut or extraction?..... YES NO
6. Has a physician or dentist ever said you had a tumor or cancer?..... YES NO
7. Are you allergic to Penicillin, Novocain, Codeine or any other medicine?..... YES NO
   If so, what? _____
8. Are you allergic to anything other than medicine? (e.g. latex or metals)?..... YES NO
   If so, what? _____

Do you have or ever had:

1. Radiation treatment..... Yes No
2. Heart Disease/Pacemaker..... Yes No
3. Anemia/leukemia/low platelets..... Yes No
4. Epilepsy/seizures..... Yes No
5. Asthma/hay fever..... Yes No
6. Tuberculosis..... Yes No
7. Diabetes/How long?_____..... Yes No
8. Kidney trouble..... Yes No
9. Liver trouble/jaundice..... Yes No
10. Thyroid trouble/goiter..... Yes No
11. Fainting/dizziness..... Yes No
12. Glaucoma..... Yes No
13. Arthritis..... Yes No
14. HIV/AIDS/syphilis/VD/hepatitis..... Yes No
15. Stroke..... Yes No
16. Stomach ulcer..... Yes No
17. Heart murmur..... Yes No
18. Eczema/hives..... Yes No
19. Psychiatric treatment..... Yes No
20. Are you pregnant?..... Yes No

Are you now taking:

1. Fosamax/Boniva/Actonel..... Yes No
2. Drugs for high blood pressure..... Yes No
3. Drugs for sleep..... Yes No
4. Cortisone/steroids/ACTH..... Yes No
5. Anticoagulants/blood thinner/aspirin..... Yes No
6. Tranquilizers/sedatives..... Yes No
7. Antibiotics..... Yes No
8. Insulin..... Yes No
9. Please list any medications you are taking (RX or otherwise):

_____
_____
_____
_____
_____
_____

Pharmacy: _____

I Understand That Payment Is Due At Time Of Service.
I will pay today by: CASH ❑ CHECK ❑ CREDIT CARD ❑

I verify that the preceding information is true. I authorize the release of information to my insurance company. I will allow Neo Dental Care to discuss my conditions with my physician(s) and to request medical information from them. I authorize Neo Dental Care to obtain and verify a credit report. I also acknowledge that I have been given or offered a copy of the office's "Notice of Privacy Practices".

Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____
Signature _____ **Date** _____

Treatment Organizer

Preferred Name________________________ **Spouse**__________________________ **Date**_________________

Family____ **Email or Text?** **Yes** **No**

Units / Prod.	Order / Rm #	Description	Date / Time	
				Est. ________ **Date** ________ **Est. Ins.** ________ **Ded** ________ **Est. Pt.** ________ **Sig.** ________
				Est. ________ **Date** ________ **Est. Ins.** ________ **Ded** ________ **Est. Pt.** ________ **Sig.** ________
				Est. ________ **Date** ________ **Est. Ins.** ________ **Ded** ________ **Est. Pt.** ________ **Sig.** ________
				Est. ________ **Date** ________ **Est. Ins.** ________ **Ded** ________ **Est. Pt.** ________ **Sig.** ________
				Est. ________ **Date** ________ **Est. Ins.** ________ **Ded** ________ **Est. Pt.** ________ **Sig.** ________

The totals and subtotals above are **ESTIMATES** for treatment that is known. These totals and subtotals would not include any other treatment or service that is not listed above. Other treatment or service may become necessary due to circumstances or treatment not considered at this time. The cost of the treatment or service is always the responsibility of the patient.

Signature:____________________________________ **Date:** ____________________

Notes ____