PATIENT REGISTRATION

Date:____________________Patient's Date of Birth:_____________________Age:________ Sex: M F

Name:______________________, ________________, _____ SS#:________-______-___________
Last First M.I.

Mailing Address:____
Street/P.O. Box # City/State/Zip

Home Phone:__________________Work Phone:_____________________Cell Phone:_________________

Employer:____

Email address:____

Has the patient been seen by Dr. Fleischmann before? (Circle one): Yes No If yes, approximately when?___

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RESPONSIBLE PERSON INFORMATION
(Please fill in if different from above)

Person Responsible for Payment:____
(parent if patient is under 18 years of age)

Mailing Address:____
Street/P.O. Box # City/State/Zip

Home Phone:_____________________________________ Work Name & Phone #:_____________________

SSN:________-_______-_________ Date of Birth:___________Relationship to Patient:__________________

Next of Kin/Emergency Contact:____
Name Relationship to Patient

____
Address Phone

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INSURANCE INFORMATION: (PLEASE PRESENT YOUR INSURANCE CARD FOR COPYING)

Primary Coverage (Circle one): Yes No
Insurance Name:________________________________ Employee:_________________________________

Policy # (usually SSN):__________________________ Group Number:___________________________
or Employer

Secondary Coverage (Circle one): Yes No
Insurance Name:________________________________ Employee:_________________________________

Policy # (usually SSN):__________________________ Group Number:___________________________
# of Employer

FOR OUR PATIENTS WHO HAVE MEDICARE COVERAGE: If your treatment in this office is of a dental nature, Medicare will not pay for these services. Medicare does not allow coverage for dental treatment of mouth, teeth or jaws. Payment for these services will be your responsibility.

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of treatment. I hereby authorize payment directly to Dr. Fleischmann for insurance benefits otherwise payable to me. I understand that I may request a copy or to view the office Notice of Privacy Practices (HIPAA) policy.

Responsible Party Signature:____
(patient or parent/guardian)

PLEASE FILL OUT FRONT AND BACK

MEDICAL AND DENTAL HISTORY

Age:___________
Height:_________
Weight:_________

Purpose of this appointment:______________________Referred to this office by:______________________

Your physician's name:____Last medical exam:_________

Your dentist's name:____Last dental exam:___________

Have you been hospitalized in the last five (5) years: yes no If so, for what?________________________

DO YOU NOW HAVE OR HAVE YOU EVER HAD: (Please circle YES or NO)

Abnormal Bleeding yes no
Hepatitis yes no
If yes what type A, B, C.
Liver damage yes no
Abnormal blood pressure yes no
If yes, (please circle) high or low
Heart murmur yes no
Heart bypass/Balloon angioplasty yes no
If yes, when?____________
Heart Attack yes no
If yes, when_____________________
Rheumatic Fever yes no
Stroke/Paralysis yes no
Heart Failure yes no
Asthma/Breathing problem yes no
If so, do you use an inhaler? yes no
When was your last attack? ____________
Have you ever been on steroid pills for your asthma? yes no
Have you ever spent overnight in the hospital because of asthma? yes no
Epilepsy/Convulsions yes no
Diabetes yes no
If so, how controlled_______________________
(diet, oral meds, insulin..)
Ulcers yes no
Frequent heart burn yes no
Kidney Trouble yes no
Have you had a joint replacement (i.e. total hip, knee, etc.)? yes no
Do you now or have you in the past smoke or chew tobacco? yes no
How much ___________ how long ___________
Do you have other physical condition(s) we should be aware of? yes no
Please explain:______________________________
____
____

Do you wear contact lenses? yes no

WOMEN ONLY:
Are you pregnant? yes no
Or a nursing mother? yes no

ALLERGIES

Have you had a reaction or are you allergic to:

Local anesthesia
(novocaine or any similar type drug) yes no
Penicillin yes no
Codeine yes no
Latex yes no
Other allergies not listed above:________________
____
____

ANESTHESIA

Have you had a general anesthetic (gone to sleep for an operation)? yes no

Have you or any blood relative had a complication from a general anesthetic? yes no
Please describe:______________________________
____
____

Do you take Coumadin or any other blood thinners? yes no

Have you taken Prednisone or any other steroids within the last month? yes no

Please list any medications you are now taking:
____
____
____
____

May we request your medical or dental records if they are needed? yes no

Signed:____________________________________
(patient or parent/guardian)