ADULT REGISTRATION FORM Date_______________

Section I Patient Information

NAME:____ PREFERRED NAME:____________________________

ADDRESS:____ HOME PHONE NO:____________________________

CITY:__________________________ STATE:__________ZIP:________________ WORK PHONE NO:____________________________

CELL PHONE NO:____________________________

EMAIL ADDRESS:____________________________

GENDER: M / F MARITAL STATUS: S M D W SOCIAL SECURITY NO:____________________________

DATE OF BIRTH:____________________________

Section II Health History

IT IS VERY IMPORTANT THAT WE KNOW ABOUT YOUR MEDICAL/DENTAL HISTORY. MANY THINGS HAVE A DIRECT BEARING ON DENTAL HEALTH/TREATMENT. ALL INFORMATION IS CONFIDENTIAL.

PHYSICIAN'S NAME:______________________________________ PHONE NUMBER:____________________________

Are you currently under a physician's care? Y N (please circle one)

Reason:____

CURRENT MEDICATIONS:____

RECENTLY HOSPITALIZED? Y N (please circle one) REASON:____

WOMEN: ARE YOU PREGNANT? Y N (please circle one) NURSING? Y N (please circle one)

PLEASE CHECK YES OR NO TO THE FOLLOWING.

YES	NO		YES	NO	
___	___	AIDS/HIV	___	___	HEPATITIS A / B / C (please circle one)
___	___	ABNORMAL BLEEDING	___	___	HERPES/FEVER BLISTERS
___	___	ANGINA (CHEST PAINS)	___	___	HIGH/LOW BLOOD PRESSURE
___	___	ANEMIA	___	___	KIDNEY PROBLEMS
___	___	ARTIFICIAL HEART VALVE	___	___	LIVER DISEASE
___	___	ARTIFICIAL JOINT REPLACEMENT	___	___	MITRAL VALVE PROLAPSE
___	___	ASTHMA /EMPHYSEMA	___	___	PACE MAKER
___	___	CANCER/TUMOR OR MALIGNANCY	___	___	PSYCHIATRIC CARE
___	___	CHEMO/RADIATION	___	___	REFLUX
___	___	CURRENT/PAST TOBACCO USE	___	___	RHEUMATIC/SCARLET FEVER
___	___	DIABETES	___	___	RESPIRATORY PROBLEMS
___	___	TAKING INSULIN	___	___	STROKE
___	___	EPILEPSY/SEIZURES	___	___	TUBERCULOSIS
___	___	HEART MURMUR	___	___	VENEREAL DISEASE
___	___	HEART ATTACK DATE:_____________	___	___	ALLERGIC TO LATEX
___	___	STENTS PLACED	___	___	ALLERGIC TO PENICILLIN

PLEASE LIST ALL OTHER ALLERGIES OR MEDICAL CONCERNS:____

____

Section III Insurance Information

PRIMARY DENTAL BENEFIT PLAN

NAME OF POLICY HOLDER:____________________ **EMPLOYED BY:**____________________

POLICY HOLDER'S DATE OF BIRTH:____________________ **POLICY HOLDER'S SSN:**____________________

NAME OF DENTAL INSURANCE CO:____________________ **INSURANCE CO PHONE #:**____________________

DENTAL IDENTIFICATION #:____________________ **RELATIONSHIP TO POLICY HOLDER:**____________________

SECONDARY DENTAL BENEFIT PLAN **(IF APPLICABLE)**

NAME OF POLICY HOLDER:____________________ **EMPLOYED BY:**____________________

POLICY HOLDER'S DATE OF BIRTH:____________________ **POLICY HOLDER'S SSN:**____________________

NAME OF DENTAL INSURANCE CO:____________________ **INSURANCE CO PHONE #:**____________________

DENTAL IDENTIFICATION #:____________________ **RELATIONSHIP TO POLICY HOLDER:**____________________

Section IV Misc. Patient Information

EMERGENGY CONTACT PERSON:____________________ **TELEPHONE NUMBER:**____________________

RELATIONSHIP TO PATIENT:____________________

APPROX. DATE OF LAST DENTAL X-RAYS:____

FAMILY MEMBERS WHO ARE PATIENTS IN OUR PRACTICE:____

____

WHOM MAY WE THANK FOR YOUR REFERRAL? ____

- I hereby authorize Gane & Karshner DDS, Professional Association to submit claims and assign benefits, on my behalf, to my Insurance Company(s) listed above.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

*SIGNATURE:*____ *DATE:*____________________

I AM THE (PLEASE CHECK ONE): ____ AD**ULT PATIENT** ____ **PARENT OR GAURDIAN**