Patient Information

Patient Name: _____/_____ Date:_____
Last First MI (preferred name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Whom may we thank for referring you to our practice? _____

Health Information

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

☐ AIDS
☐ Allergy to foods
_____
☐ Allergy to medication
- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other (list)

_____
☐ Allergy – other
_____
_____
_____

☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Cancer
☐ Cardiac Condition
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse

_____
☐ Cosmetic Implants
☐ Diabetes
☐ Dizziness / Fainting

☐ Epilepsy
☐ Excessive Bleeding
☐ Glaucoma
☐ Head Injuries
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____

☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Ulcers
OTHER MEDICAL – list:

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- List any medications, supplements, homeopathics and/or herbs you are taking: _____

Dr. Regiani is well educated in alternative therapies. We can offer homeopathic as well as conventional drug medications. If you need medications, which would you prefer: *(number 1st, 2nd, 3rd choice, if applicable)*

For pain: Traditional:_____ Homeopathic_____ Other_____
Antibiotic/Infection: Traditional:_____ Homeopathic_____ Other_____

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 doctor at the next appointment without fail.

I hereby authorize Dr Regiani and his staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my (or my child's) dental needs.

Upon such diagnosis, I authorize Dr Regiani and his staff to perform all recommended treatment and to employ such assistance as required to provide proper care, including consultation with my health care provider(s).

I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents carries certain risks, and I understand I may ask for a full recital of possible complications.

As a condition of treatment, payment is expected at time of service unless written financial arrangements are made and signed with this office. I understand that any fee estimate is valid for treatment that begins within 90 days from the date of the examination, and is subject to change due to unforeseen circumstances. A finance charge of 1-1/2% per month (18% APR) is added to unpaid balances at 60 days after treatment. If no payments are received within a 90 day period, collection action will commence, and I agree to pay all attorney and legal fees associated with collecting my unpaid delinquent balance.

I have read and understand the above conditions of treatment and payment.

Signature of Responsible Party_____ Date:_____

Printed name, if not signed by patient_____ Relationship:_____