Memorial City Smiles

PATIENT REGISTRATION FORM

Please fill out all fields completely. Thank you.

How did you hear about us?
☐ Patient Referral ☐ Online Search ☐ Website ☐ Google Ad ☐ ZocDoc ☐ Newsletter/Magazine ☐ Post Card ☐ Other___________

Whom should we thank for referring you to our practice?

Patient is: ☐ Policy Holder ☐ Responsible Party

1. Patient Information:

First Name:		Last Name:	M.I.
Birth Date:	Age:	SSN:	Driver License Number:

Address:	Address 2:

City:	State:	Zip Code:
Cell Phone:	Home Phone:	Work Phone: Ext:
Emergency Contact Name:	Emergency Phone#:	Relationship:

☐ Insurance Policy Holder

E-mail Address:	*I would like to receive correspondences via email ☐* *I would like to receive correspondences via phone ☐*
Can we leave voicemails on your phone? Yes ☐ No ☐	*I would like to get appointment reminders via text message ☐* *(standard text messaging rates apply)*

Sex: Male ☐ Female ☐	Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐
Employment Status: Full Time ☐ Part Time ☐ Retired ☐	Student Status: Full Time ☐ Part Time ☐

2. Responsible Party (If other than patient): *If patient is the policy holder, please skip to #3.*

First Name:		Last Name:	M.I.
Birth Date:	Age:	SSN:	Driver License Number:

Relationship to Patient:

Address:	Address 2:

City:	State:	Zip Code:
Cell Phone:	Home Phone:	Work Phone: Ext:

☐ Responsible Party is also a Policyholder for Patient

E-mail Address:	*I would like to receive correspondences via email ☐* *I would like to receive correspondences via phone ☐*
Can we leave voicemails on your phone? Yes ☐ No ☐	*I would like to get appointment reminders via text message ☐* *(standard text messaging rates apply)*

3. Insurance Information:

Name of Insured:	SSN of Insured:	Date of Birth of Insured:

Member ID #:	Group #:

Relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐ (Please Specify) ____________________

Employer:	Name of Insurance Company:

Insurance Company's Phone number: (   )   -

Please contact your insurance or refer to your insurance hand book for the following information:

What is your maximum Annual Benefit? $_______	What is your Annual Deductible? $_______
Remaining Annual Benefits: $_______	Remaining Annual Deductible: $_______
Do you have a waiting period? ☐ Yes ☐ No How long? ___________	Do you have a missing tooth clause? ☐ Yes ☐ No
How many dental cleanings are covered per year? _______________	What is the duration in between cleanings? _______

Patient's (or responsible party's) Signature:	**Date:**

Karam Rassam, D.D.S

MEDICAL HISTORY

PATIENT NAME ____ Birth Date ____________________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________________
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ____________________

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ____________________

Comments: ____
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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ______________