PATIENT REGISTRATION – *Please Print*

PATIENT ____________________ ☐Mr. ☐Mrs. ☐Miss ☐Ms. **TODAY'S DATE** ________

Last Name First Name Middle Initial

Address ____________________ Home Phone ________

____________________ Work Phone ________

City State Zip

Patient's relationship to person responsible for bill: ☐Self ☐Spouse ☐Child ☐Dependent

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced Birthdate ________ Age ________

Sex: ☐Male ☐Female Soc. Sec. # ________ Driver's License # ________

Referred to this office by: ________

Patient's Employer ________

Address ________

City, State, Zip ________

Occupation ________

Spouse's Name ________

Spouse's Employer ________

Home Phone ________ Work Phone ________

Occupation ________

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

Name ________

Mailing Address ________

City, State, Zip ________

Home Phone ________ Work Phone ________

Employer ________

Address ________

City, State, Zip ________

Occupation ________

Spouse's Name ________

Spouse's Employer ________

Address ________

City, State Zip ________

Work Phone ________

Occupation ________

Subscriber DOB ________

INSURANCE AND/OR INJURY INFORMATION

Insurance ________

Subscriber's Name ________

Group # ________

ID # ________

Patient's relationship to subscriber:
☐Self ☐Spouse ☐Child ☐Dependent

Subscriber's Employer ________

Other Insurance ________

Subscriber's Name ________

Group # ________

ID # ________

Patient's relationship to subscriber:
☐Self ☐Spouse ☐Child ☐Dependent

Subscriber's Employer ________

If injured: Date ________ Place: ☐ Home or school ☐ Work ☐ Auto accident ☐ ________

Nature or cause of injury: ________

In case of emergency, local friend or relative to be notifed (not living at same address).

Name ________ Relationship To Patient ________

Home phone ________ Work phone ________

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim.

SIGNED: ________

Reorder from Forms Management Health Care Division 1-800-735-7135

TACOMA DENTURE CLINIC NEW PATIENT - PLEASE COMPLETE ALL QUESTIONS.

1. NAME ______________________________ REFERRED BY ______________
2. ADDRESS ______________________________ PHONE ______________
3. CITY ______________________ STATE ______ ZIP ______________
4. EMPLOYER ______________________________ WORK PHONE ______________
5. BIRTHDATE ____________________ SOCIAL SECURITY NO. ______________
6. SPOUSE'S NAME ____________________ EMPLOYER ______________
7. WHEN WAS YOUR LAST PHYSICAL EXAM __________ DENTAL EXAM ______________
8. ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? ______________
9. PHYSICIAN'S NAME ______________________ PHONE ______________
10. ARE YOU ALLERGIC TO ANY MEDICATIONS? ________ PLEASE LIST ______________
    ____
11. ARE YOU ALLERGIC TO ANY ANESTHETICS? ______________________________
12. LIST ALL MEDICATIONS YOU'RE TAKING (INCLUDING OVER-THE-COUNTER MEDS)
    ____
    ____
    ____
13. HAVE YOU HAD DENTAL X-RAYS IN THE PAST YEAR? ______________
14. WHAT WAS YOUR LAST DENTAL TREATMENT? ______________
15. HAVE YOU EVER HAD MAJOR DENTAL TREATMENT/ORTHODONTICS? ______________
16. DO YOU REGULARLY USE TOBACCO PRODUCTS? ______________
17. DO YOU REGULARLY USE ALCOHOL/DRUGS? ______________
18. WHAT IS YOUR CHIEF DENTAL CONCERN AT THIS TIME? ______________
    ____
19. EMERGENCY CONTACT ______________________ PHONE ______________
20. DENTAL INSURANCE COMPANY ______________________________
21. SUBSCRIBER NAME ______________________ GROUP NUMBER ______________
22. SOCIAL SECURITY NUMBER ________________ EMPLOYER ______________
23. IS THIS TREATMENT THE RESULT OF AN ACCIDENT OR INJURY? ______________
24. IF SO, PLEASE EXPLAIN ______________________________

PLEASE CHECK ANY CONDITIONS FOR WHICH YOU HAVE SOUGHT MEDICAL TREATMENT:

___EYE PROBLEMS	___HEART PROBLEMS	___SEVERE HEADACHES
___EAR PROBLEMS	___HIGH BLOOD PRESSURE	___NOSE / SINUS DISORDER
___DIALYSIS	___HEART MURMUR	___KIDNEY PROBLEMS
___CANCER	___BLOOD DISORDERS	___PACEMAKER
___BRONCHITIS	___BYPASS SURGERY	___HEPATITIS
___EMPHYSEMA	___RESPIRATORY PROBLEMS	___DIABETES
___LIVER DISEASE	___RHEUMATIC FEVER	___THYROID PROBLEMS
___SKIN DISORDER	___JOINT IMPLANTS	___ARTHRITIS
___STEROIDS	___EXCESSIVE BLEEDING	___STROKE
___TMJ PROBLEMS	___DEPRESSION	___ASTHMA
___HIV POSITIVE / AIDS	___STOMACH PROBLEMS	___ANGINA
___HERPES / CANKER SORES	___TUBERCULOSIS	___EPILEPSY

ARE YOU CURRENTLY PREGNANT? __________ ARE YOU BREASTFEEDING? __________

PLEASE LIST ANY OTHER MEDICAL PROBLEMS ______________________________

____

____

SIGNATURE ______________________________ DATE ______________

Rev. 6/2002