For office use only: Acct. No. _____ Acct. Name _____

Wahl Family Dentistry

REGISTRATION FORM

Name (first)_____(middle initial)_____(last) _____

Address_____

City_____State_____Zip_____

Occupation_____ Social Security #_____Birthdate_____Sex____

Telephone (Home)_____(Work)_____(Cell phone)_____

Email _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employed By _____

If self employed, name of business/address_____

Employer's Address_____

☐YES ☐NO Are you a full time student? If so, which school? _____

Whom can we thank for referring you?_____

Hobbies/interests_____Nickname_____ Spouse's

name_____Spouse's Social Security #_____

Occupation of spouse_____Spouse's work phone_____cellphone_____

Spouse's birthdate_____Name of spouse's employer_____

Spouse's employer's address_____

Person to notify in an emergency (not at home address)_____Phone _____

Dental Insurance Information

Insured is ☐ self ☐ husband ☐ wife ☐ mother ☐ father Insured plan # _____

Name of Employer_____Employee's Name

_____Employee's Social Security #_____

Insurance Co._____Group #_____Employee's date of birth_____

Insurance Co. Address_____ Insurance Co. Phone _____

☐YES ☐NO Are you covered by a second insurance company?

If yes, name of 2nd insurance co._____Group #_____Employee name

for 2nd ins. co._____Social Security # for 2nd ins. co._____

Employee birthdate for 2nd ins. co. _____

Must complete if under 18 or full time student/ Responsibility Party Information Required

Mother's Name_____Mother's Social Security #_____

Mother's Address_____

Mother's Home Phone #_____(Cell phone)_____Birthdate_____

Mother's Employer_____Occupation_____Work Phone _____

Father's Name_____Father's Social Security #_____ Father's

Address_____ Father's

Home Phone #_____(Cell phone)_____Birthdate_____

Father's Employer_____Occupation_____Work Phone _____

Please turn the page!

Health Questions

☐YES ☐NO Would you like whiter and/or straighter teeth? (Ask about whitening and/or Invisalign.)
☐YES ☐NO Is your general health **good**?
☐YES ☐NO Do you have any **allergies** to any foods, medications, metals, or earrings?

If so, which ones?_____

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

☐YES ☐NO Heart trouble?
☐YES ☐NO Heart murmur?
☐YES ☐NO Mitral valve prolapse?
☐YES ☐NO Leaky heart valve?
☐YES ☐NO Infective endocarditis?
☐YES ☐NO Artificial (prosthetic) heart valve or valves?
☐YES ☐NO Asthma?
☐YES ☐NO Bleeding problems?
☐YES ☐NO Epilepsy?
☐YES ☐NO Hepatitis?
☐YES ☐NO Females: are you pregnant?
☐YES ☐NO Artificial (prosthetic) joints?
If yes, when was the artificial joint placed? _____
☐YES ☐NO Infected artificial joint?
☐YES ☐NO Hemophilia?
☐YES ☐NO Malnourishment?
☐YES ☐NO Systemic lupus erythematosus?
☐YES ☐NO Rheumatoid arthritis?
☐YES ☐NO HIV or AIDS?
☐YES ☐NO Immunosuppresion?
☐YES ☐NO Radiation therapy?
☐YES ☐NO Diabetes?

Updates
(for office use only)

Any changes? ☐YES ☐NO
If so, what?_____
_____
___
Date _____Initials
_____

Any changes? ☐YES ☐NO
If so, what?_____
_____
___
Date _____Initials
_____

Any changes? ☐YES ☐NO
If so, what?_____
_____
___
Date _____Initials
_____

Any changes? ☐YES ☐NO
If so, what?_____
_____
___
Date _____Initials
_____

Any changes? ☐YES ☐NO
If so, what?_____
_____
___
Date _____Initials

☐YES ☐NO Is there any other information about your health which should be known?

If so, what? _____

Please list *all* current medications _____

Physician name, address, and telephone (if known) _____

Patient Name: _____

X_____Date _____
Signed (patient or parent if minor)

I understand that as a service to me Wahl Family Dentistry will assist me in processing my insurance claims. However, I am completely responsible for all fees in their entirety.

X_____Date_____
Signed (patient or parent if minor)

I authorize the use of my radiographs and/or photographs for use in seminars or publications of Wahl Family Dentistry.

X_____Date_____
Signed (patient or parent if minor)

I have received the Wahl Family Dentistry Notice of Privacy Practices.

X_____Date_____
Signed (patient or parent if minor)

ONLY if you have insurance: SIGNATURE ON FILE

So you don't have to sign an insurance form at each dental visit, Wahl Family Dentistry will maintain this "signature on file" for you.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

x_

Signed (patient or parent if minor)
AUTHORIZATION TO PAY BENEFITS TO BELOW NAMED DENTIST: I hereby authorize payment directly to Wahl Family Dentistry for services rendered.

X_____Date_____
Signed (subscriber or patient or parent if minor)

Telephone calls at Wahl Family Dentistry may be monitored for quality assurance and employee training. The highest compliment our patients can give us is the referral of their friends and family. Thank you for your trust.