Morrison Dental Group 

PATIENT INFORMATION:

Patient Registration Form

Date:_____

I was referred to this practice by: _____

Chart#:_____ Email for Appointment Reminders: _____

Last Name:_____ First Name:_____ Middle Initial: _____

Street Address:_____ Apt#:_____ City:_____ State:_____ Zip: _____

Mailing Address (If Different): _____ Apt#:_____ City: _____ State:_____ Zip: _____

SS#:_____ Home Phone:_____ Work Phone:_____ Cell:_____

Sex: Male ☐ Female ☐ Marital Status: S ☐ M ☐ D ☐ W ☐ Date of Birth:_____ Age: _____

Occupation:_____ If Student, School: _____

Employer:_____ Address:_____ Phone:_____

Spouse's Name_____ Employer: _____ Spouse SS#: _____

Emergency Contact (Name): _____ Emergency Contact Phone: _____

Preferred contact method for appointment reminders? (check all that apply): Text me! ☐ Call me! ☐ Email me! ☐

RESPONSIBLE PARTY (if different from the patient):

Last Name:_____ First Name:_____ Middle Initial: _____

Address:_____ Apt#:_____ City:_____ State:_____ Zip: _____

SS#:_____ Date of Birth:_____ Relationship to Patient: Spouse ☐ Parent ☐ Other ☐ _____

Home Phone:_____ Work Phone:_____ Occupation: _____

Employer:_____ Address:_____ Phone:_____

PRIMARY DENTAL INSURANCE INFORMATION:

Insurance Company Name:_____ Phone#: _____

Claims Address: _____

Policy ID#:_____ Group#:_____ Plan#: _____

Policyholder's Name:_____ SS#: _____

Insurance Subscriber's Mailing Address (if different from patient): _____

Date of Birth:_____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ _____

Employer:_____ Address:_____ Phone:_____

SECONDARY INSURANCE INFORMATION (DENTAL):

Insurance Company Name:_____ Phone#: _____

Claims Address: _____

Policy ID#:_____ Group#:_____ Plan#: _____

Policyholder's Name:_____ SS#: _____

Insurance Subscriber Mailing Address (if different than above): _____

Date of Birth:_____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ _____

Employer:_____ Address:_____ Phone:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

-You May Refuse to Sign This Acknowledgement-

I,_____, have reviewed a copy of this office's Notice of Privacy Practices.

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical _____

Have you ever had any of the following? (Check boxes that apply):

- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Latex Allergy
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Alzheimers
- ☐ Dementia
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Mitral Valve Prolapse
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Blood Thinners
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ AIDS/HIV
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____

If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time?_____ If so, what? _____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? _____

If patient is a child, what is his/her weight? _____

(Woman) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

Have you had any x-ray's in the last 5 years at another dental practice? ☐ Yes ☐ No

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature _____