Bucktown Dental Associates

Adult Registration Form

Today's Date ____________________

PATIENT'S INFORMATION

Patient Last Name ______________________ First Name _________________ Date of Birth _____________

Home Address ____ City & Zip Code _________________

Home Phone ___________________ Cell Phone ______________________

Email address _______________________________________ Social Sec No. _____________________

Name of the person who brought child patient __________________________ Relationship ______________

Emergency contact ____ **Phone** __________________

How did you hear about our office:

Internet ☐ Outer sign ☐ Insurance ☐ Other __________________________________

PERSON RESPONSIBLE FOR THE ACCOUNT/ GUARDIAN

Name ____ Social Security Number ___________________

Relationship to Patient ___________________________________

Address _____________________________________ City _________________ State ________ Zip _______

Home phone ______________________ Cell _____________________ Work ______________________

Email ____

INSURANCE INFORMATION

Name of Insurance ____

Name of Insured ____________________________________ Relationship to Patient ___________________

Social Security Number __________________________ Date of Birth _______________________________

Address of Insured _____________________________City ______________ State ________ Zip ________

Home Phone ____________________ Cell Phone ______________________ Employer _____________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my Insurance, address, and/or phone number.
I authorize the dentist & staff to take x-rays, administer local anesthetics, and perform any services needed during diagnosis & treatment. The dentist and staff will provide the best dental care possible. However, no guarantee can be made as to the success of treatment.
I authorize the office to release information to insurance companies and third-party payers. I also authorize the insurance companies and third party payers to send payments directly to the dentist. I understand that I am fully responsible for payment of all services. I also understand that an adult accompanying a minor is responsible for the account. Payment is due at the time of service unless other arrangements have been made with the office.
If my insurance company has not paid my account in full within 60 days, the balance will be transferred to my account. A 1.5% monthly administrative fee and $5 billing fee will be added to balances not paid in 30 days.
If account is not paid within 90 days of service and no financial arrangements have been made, I understand that I will be responsible for legal and collection fees in addition to interest and all other expenses incurred in collecting my account. The office may delay or forego enforcing any of its rights or remedies without losing them.
I acknowledge that I was provided with a copy of Notice of Privacy Practices (posted in waiting area and on the office website.)

Name of person filling this form ______________________________ **Signature** ____________________________

HEALTH HISTORY

Physician's Name ____________________ **Phone**__________

Are You Taking any of the following:

1. Recreational drugs? Y N
2. Medications, over the counter medicines? Y N
   List: ______________________________
3. Tobacco in any form? Y N
4. Alcohol? Y N

5. Medications for osteoporosis? Y N
6. **Bisphosphonates** (Bonivia, Fosamax, Actenol, alendronate) Y N
7. Steroids Y N
8. Immunosuppressant Y N
9. Anticoagulants (blood thinners) including Asprin Y N

Are you allergic to any of the following:

5. Latex Y N
6. Penicillin or other antibiotics -------------- Y N
7. Local anesthetics Y N
8. Asprin Y N
9. Ibuprofen Y N
10. Other medications Y N

Do You Have or Have You Had:

11. Bleeding problems, bruising easily? Y N
12. Heart attack, heart defects? Y N
13. Heart disease? Y N
14. Heart murmurs? Y N
15. Rheumatic fever? Y N
16. Pacemaker? Y N
17. Prosthetic heart valve? Y N
18. High blood pressure? Y N
19. Stroke, hardening of arteries? Y N
20. Diabetes? Y N
21. Family history of diabetes? Y N
22. Asthma? Y N
23. VD (syphilis or gonorrhea)? Y N
24. HIV/AIDS Y N
25. Hepatitis, other liver disease? Y N
26. Kidney, bladder disease? Y N
27. Thyroid, adrenal disease? Y N
28. Artificial joint? Y N
29. Stomach problems, ulcers? Y N
30. Gastroesophageal Reflux Disease (GERD) Y N
31. Anemia? Y N
32. Tumors, cancer? Y N
33. Radiation treatments? Y N
34. Chemotherapy? Y N
35. TB, or lung disease? Y N
36. Sleep apnea Y N
37. Anxiety Y N
38. Depression Y N
39. ADHD Y N

Women Only

35. Are you or could you be pregnant? Y N
36. Are you nursing? Y N
37. Taking birth control pills? Y N

Name of person filling this form ____________________ **Signature** ____________________