Print Form

Daniel N. Galaif, D.D.S.

PATIENT REGISTRATION

Please Print **Today's date:** / /

PATIENT INFORMATION

Name *(Last, First, M.I.):* Birth Date: / /

What is your preferred name? Home Phone #: ( )

Street Address: Apt #: Pager/Cell Phone #: ( )

City: State: Zip: E-Mail Address:

Occupation: Soc. Sec #:

Employer: Business Phone #: ( )

Business Street Address:

City: State: Zip:

Spouse/Parent Name
(Last, First, MI): Spouse/Parent Phone: #: ( )

E-Mail Address:

Whom can we thank for referring you to us?

RESPONSIBLE PARTY

Person responsible for account: Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name *(Last, First, MI):* Birthdate: / /

Street address: Apt #: Phone #: ( )

City: State: Zip: Pager/Cell Phone #: ( )

Occupation: E-Mail Address:

Employer: Soc. Sec. #:

Business Street address: Business Phone #: ( )

City: State: Zip: Drivers License #:

INSURANCE INFORMATION (Please give your insurance card to the receptionist)

Is this patient covered by insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of Primary Insurance:

Subscriber's name: Birthdate: / /

Subscriber's Soc. Sec #: Policy. #: Group #

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

Name of secondary insurance (if applicable):

Subscriber's name: Birthdate: / /

Subscriber's Soc. Sec #: Policy. #: Group #

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

IN CASE OF EMERGENCY

In case of emergency, who should be notified?

Home Phone #: ( ) Work Phone: ( ) Cell Phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to this office. I understand that I am financially responsible for any balance. I also authorize Daniel N. Galaif, D.D.S., or insurance company to release any information required to process my claims.

Signature *Relationship to Patient* *Date*

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DENTAL & MEDICAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your dental record.

Patient Name *(Last, First, M.I.):* _____

Previous Dentist: _____ Phone #: ( )

Date of last visit: / /

Physician's Name: _____ Phone #: ( )

Date of last physical: / /

PERSONAL HEALTH HISTORY

Have You Ever Had The Following: ☐ Yes ☐ No **If yes, please check the boxes that apply:**

☐ Heart Attack/Stroke	☐ Mitral Valve Prolapse	☐ Asthma	☐ Liver Problems	☐ Skin Rash
☐ Aids/HIV+	☐ Heart Murmur	☐ Ulcers/Colitis	☐ Drug/Alcohol Abuse	☐ Diabetes
☐ Exposed to HIV, but Negative	☐ Rheumatic Fever	☐ Epilepsy	☐ Mononucleosis	☐ Lupus
☐ Abnormal Bleeding/Hemophilia	☐ Blood Disease	☐ Convulsions	☐ Venereal Disease	☐ Herpes
☐ High/Low Blood Pressure	☐ Severe Headaches	☐ Hearing Impaired	☐ Sinus Problems	☐ Hives
☐ Artificial Valves/Joints/Bones	☐ Cancer/Chemotherapy	☐ Hepatitis	☐ Psychiatric Problems	☐ Diabetes
☐ Heart Surgery/Pacemaker	☐ Anemia	☐ Kidney Problems	☐ Tuberculosis (TB)	☐ Shingles

Have you had any other serious Illness? ☐ Yes ☐ No If yes, please list:

_____ _____

_____ _____

Have you had any Hospital Stays or Operations? ☐ Yes ☐ No

Have you ever taken any diet pills such as Phen-Fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No

If yes, when: _____

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Are you nervous about having dental treatment ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a bad experience in a dental office? ☐ Yes ☐ No

Are you allergic to any drugs or medicines, latex, metals/nickel or plastics? ☐ Yes ☐ No If yes, please list:

_____ _____

_____ _____

Are you currently taking any drugs/medicines (over the counter or prescribed)? ☐ Yes ☐ No If yes, please list:

_____ _____

_____ _____

WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No

Are you taking Birth Control Pills? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____ _____

Signature *Relationship to Patient* *Date*

Dentist's Initials: _____ *Date:* _____