ANTHEM DENTAL
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REGISTRATION

PATIENT NAME _____ **MALE __FEMALE __ AGE ___ DATE OF BIRTH_____**
LAST FIRST
If child, PARENT'S NAME:
_____
LAST FIRST
Nickname: _____
Single ____ Married ____ Divorced _____ Minor _____

Residence _____
City _____ State _____ Zip _____

Telephone _____ Cell _____
Business Phone _____ Ext. _____
Position: _____

Email _____

Patient SS# __ _____
Spouse SS# _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT: _____

WHO MAY WE THANK FOR THIS REFERRAL?
_____

EMERCENCY NAME AND CONTACT:
_____

DENTAL INSURANCE

PRIMARY COVERAGE

Employee: _____
Employee Date of Birth: _____
Insured SS#:_____
Employer: _____
Insurance Company: _____
Address: _____
Telephone: _____
Member ID : _____ , Group No: _____

SECONDARY COVERAGE

Employee: _____
Employee Date of Birth: _____
Insured SS#:_____
Employer: _____
Insurance Company: _____
Address: _____
Telephone: _____
Member ID : _____ , Group No: _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) care, advice and treatment to another dentist.
I understand I am responsible for all costs of dental treatment. In the event that my insurance does not pay, I understand it is my sole responsibility and agree to pay fees in full.
I hereby authorize payment of insurance benefits directly to the dentist.
I attest to the accuracy of the information on this page.
I understand that should this account become delinquent, I will be responsible for all the collection costs.

PATIENT OR GUARDIAN'S SIGNATURE: _____ DATE _____

(PLEASE CONTINUE ON BACK)

MEDICAL HISTORY

Patient's Name: _____

Last First Initial Age Date of Birth

Purpose of Visit: _____

Medical Doctor's Name: _____ Phone: _____

PLEAE CIRCLE APPROPRIATE ANSWERS:

Are you taking any medications now?	**YES**	**NO**	**UPDATE HISTORY**
Do you have allergies to medications?	**YES**	**NO**	
If so, WHAT?			
_____	**___**	**___**	
Do you have a heart murmur?	**YES**	**NO**	
Do you have Rheumatic fever?	**YES**	**NO**	
Do you have an artificial heart valve?	**YES**	**NO**	
Do you have a Pacemaker?	**YES**	**NO**	
Do you have high blood pressure?	**YES**	**NO**	
Do you have low blood pressure?	**YES**	**NO**	
Have you ever had a heart attack?	**YES**	**NO**	
Have you ever had a stroke?	**YES**	**NO**	
Are you taking Coumadin?	**YES**	**NO**	
Have you ever had surgery?	**YES**	**NO**	
If so, WHAT?			
_____	**__**	**___**	
Do you bleed excessively?	**YES**	**NO**	
Are you Diabetic?	**YES**	**NO**	
Do you have any blood disorders?	**YES**	**NO**	
Do you have any artificial joints?	**YES**	**NO**	
Or Prosthesis?	**YES**	**NO**	
Do you have asthma?	**YES**	**NO**	
Do you have kidney problems?	**YES**	**NO**	
Do you have liver problems?	**YES**	**NO**	
Have you ever had HEPATITIS?	**YES**	**NO**	
If so, WHAT Type? _____	**YES**	**NO**	
Do you have epilepsy or seizures?	**YES**	**NO**	
Do you have or ever had tuberculosis?	**YES**	**NO**	
Do you have HIV or AIDS?	**YES**	**NO**	
Do you smoke?	**YES**	**NO**	
Do you drink alcohol?	**YES**	**NO**	
Females: Are you pregnant or suspect you may be?	**YES**	**NO**	
Do you have any problems not mentioned above?	**YES**	**NO**	
If so, WHAT? _____			

Is there any special problems you want to discuss with the doctor? _____

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILES:

I certify that the above information is complete and accurate.

PATIENT OR GUARDIAN'S SIGNATURE: _____ DATE _____