WILLIAM F. FURST, D.D.S.

PATIENT REGISTRATION AND HEALTH HISTORY **DATE:**_____

Name:_____Home Phone:_____Date of Birth:_____

Home Address:_____City:_____Zip Code:_____

Social Security No.:_____Drivers License No.:_____State:_____

Employer:_____Occupation:_____Work Phone:_____

E-Mail Address:_____ **CELL Phone**:_____

Business Address:_____City:_____Zip Code:_____

Married Single Divorced Widowed

Spouse (or Parent):_____Date of Birth:_____SSN:_____

Employer:_____Occupation:_____Work Phone:_____

Business Address:_____City:_____Zip Code:_____

E-Mail Address:_____ **CELL Phone**:_____

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

Name of Insured:_____Insurance Company:_____

Name of Employer:_____ID/Social Security No.:_____

Date of Birth:_____ Group No.:_____Phone No.:_____

Claims Address:_____City:_____State:_____Zip_____

Who is financially responsible for this account?_____

THIS ACCOUNT WILL BE PAID TODAY BY: CASH CHECK CREDIT CARD CARE CREDIT

Person to contact for Emergency:_____Phone:_____
Address:_____City:_____Relationship:_____

Closest Relative not living with you:_____Phone:_____
Address:_____City:_____State:_____Zip code:_____
Relationship:_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any of the above information.

Signature:_____Date:_____

Parent (if Minor)_____Date:_____

1. Are you having pain or discomfort at this time?..... Yes No
2. Do you feel very nervous about having dental treatment?..... Yes No
3. Have you ever had a bad experience in the dental office?..... Yes No
4. Have you been a patient in the hospital during the past two years?..... Yes No
5. Have you been under the care of a physician during the past two years? Yes No
6. **Have you taken any medications or drugs during the past two years?..... Yes No**
   If yes, Please List:_____
7. When you walk up stairs or take a walk, do you have to stop because of pain in your chest, or shortness of breath, or because you are very tired? Yes No
8. Do your ankles swell during the day?..... Yes No
9. Have you gained or lost more than 10 pounds in the past year?..... Yes No
10. Do you ever wake up from sleep short of breath?..... Yes No
11. Are you on a special diet?..... Yes No
12. Has your medical doctor ever said you have a cancer or tumor?..... Yes No
13. Do you have any disease, condition, or problem not listed?..... Yes No

If yes, Please list:_____

Physician Name:_____Phone:_____

Yes No **Abnormal Bleeding**	Yes No **Fainting Spells**	Yes No **Radiation Therapy**
Yes No **Alcohol Abuse**	Yes No **Fever Blisters**	Yes No **Rheumatic Fever**
Yes No **Allergies**	Yes No **Frequent Headaches**	Yes No **Seizures**
Yes No **Anemia**	Yes No **Glaucoma**	Yes No **Shingles**
Yes No **Angina Pectoris**	Yes No **Hay Fever**	Yes No **Sickle Cell Disease**
Yes No **Arthritis**	Yes No **Heart Attack**	Yes No **Sinus Problems**
Yes No **Artificial Bones**	Yes No **Heart Surgery**	Yes No **Stroke**
Yes No **Artificial Heart Valve**	Yes No **Hemophilia**	Yes No **Thyroid Problem**
Yes No **Asthma**	Yes No **Hepatitis A**	Yes No **Tuberculosis**
Yes No **Blood Transfusion**	Yes No **Hepatitis B**	Yes No **Ulcers**
Yes No **Cancer-Tumor**	Yes No **Hepatitis C**	
Yes No **Colitis**	Yes No **High Blood Pressure**	**ALLERGIES**
Yes No **Congenital Heart Defect**	Yes No **HIV + AIDS**	Yes No **Aspirin**
Yes No **Cosmetic Surgery**	Yes No **Kidney Problems**	Yes No **Codeine**
Yes No **Diabetes**	Yes No **Liver Disease**	Yes No **Dental Anesthetic**
Yes No **Difficulty Breathing**	Yes No **Low Blood Pressure**	Yes No **Erythromycin**
Yes No **Drug Abuse**	Yes No **Mitral Valve Prolapse**	Yes No **Latex**
Yes No **Emphysema**	Yes No **Pace Maker**	Yes No **Penicillin**
Yes No **Epilepsy**	Yes No **Pneumocytistis**	**Other**_____
	Yes No **Psychiatric Problems**	

***Women only*:** Are you Pregnant? Yes No If yes, what month?_____
Are you taking Birth control Pills? Yes No

ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

*The undersigned hereby authorizes Dr. Furst to take x-rays, study models, photographs, or any other diagnostic aids deemed necessary by Dr. Furst to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Furst to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Dr. Furst choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for dependents or myself is mine; due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any balance over 60 days. In the event of default, I promise to pay any legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. **All treatment costs, regardless of insurance are the responsibility of the patient. In the event insurance does not pay, the patient is responsible for the balance.*

PATIENT SIGNATURE:_____Date:_____
(Or Responsible Party) Relationship to Patient:_____