The Dental Office at 367 Harvard Street
~ Daniel A. Goldfarb, D.M.D. ~

PATIENT REGISTRATION AND HEALTH HISTORY

Date_____
Patient's
Name_____
How do you wish
to be addressed_____

Address_____

City_____ State_____ Zip_____

E-mail_____

Home Phone_____

Cell Phone_____

Work Phone_____

Birth Date_____ M _____ F _____

Married____ Single____ Divorced____ Widowed___

Social Security #_____

Is another member of your family or relative a patient at our office?

Name(s) _____
Relationship_____

Referred to us by_____

Person to contact in emergency:

Name_____
Relationship_____
Phone number_____
Address_____

Closest relative not living with you:

Name_____
Phone number_____
Address_____
City_____ State_____ Zip_____

TELL US A LITTLE MORE ABOUT YOURSELF

Occupation/Interests_____
_____
Employer_____
Business Address_____
City_____ State_____ Zip_____
Are you a student? Yes_____ No_____
School/University_____
Year in school_____

YOUR SPOUSE:
Name_____
Occupation_____
Employer _____
Work Phone_____

DENTAL INSURANCE
Primary Carrier (Insurance Company):
_____
Subscriber's Name _____
Employer/Group Name_____
Group Number_____
Subscriber's Date of Birth_____
Subscriber's I.D. Number_____
Secondary Carrier (Insurance Company):
_____
Subscriber's Name _____
Employer/Group Name_____
Group Number_____
Subscriber's Date of Birth_____
Subscriber's I.D. Number_____

Is someone, other than yourself, financially responsible for this account? Yes____ No____
**If "yes", we require that a credit card be put on file.*
Name_____
Relationship_____
Address_____
City_____ State_____ Zip_____
Telephone_____
Credit Card: MC / Visa / Amex / Discover
Acct. #_____ Exp_____

FILL OUT REVERSE SIDE---->

HEALTH HISTORY

1. Have you been a patient in the hospital during the past two years?.....YES NO
2. Have you been under the care of a medical doctor during the past 2 years?.....YES NO
   Physician's Name_____Tel._____
   Address_____
3. Have you taken any medication or drugs during the past 2 years?.....YES NO
4. Are you now taking any medication, drugs or pills?.If so, list:_____
   _____
5. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?.....YES NO
6. Indicate which of the following you have had or have at present: Circle "Y" or "N"

Heart Failure	Y	N	Artificial Joints	Y	N	Venereal Disease	Y	N
Heart Disease or Attack	Y	N	Kidney Trouble	Y	N	A.I.D.S.	Y	N
Angina Pectoris	Y	N	Ulcers	Y	N	H.I.V. Positive	Y	N
Congenital Heart Disease	Y	N	Diabetes TYPE 1 TYPE 2		N	Cold Sores/Fever Blisters	Y	N
Heart Murmur	Y	N	Thyroid Problems	Y	N	Blood Transfusion	Y	N
High Blood Pressure	Y	N	Glaucoma	Y	N	Hemophilia	Y	N
Arteriosclerosis	Y	N	Cosmetic Surgery	Y	N	Anemia	Y	N
Mitral Valve Prolapse	Y	N	Emphysema	Y	N	Sickle Cell Disease	Y	N
Artificial Heart Valve	Y	N	Chronic Cough	Y	N	Bruise Easily	Y	N
Heart Pacemaker	Y	N	Tuberculosis	Y	N	Liver Disease	Y	N
Heart Surgery	Y	N	Asthma	Y	N	Yellow Jaundice	Y	N
Rheumatic Fever	Y	N	Hay Fever	Y	N	Epilepsy or Seizures	Y	N
Arthritis	Y	N	Allergies or Hives	Y	N	Fainting or Dizzy Spells	Y	N
Rheumatism	Y	N	Sinus Trouble	Y	N	Nervousness	Y	N
Cortisone Medicine	Y	N	Radiation Therapy	Y	N	Psychiatric Disorder	Y	N
Drug Addiction	Y	N	Chemotherapy	Y	N	Developmentally Disabled	Y	N
Stroke	Y	N	Hepatitis A B C		N	Mentally Disabled	Y	N

7. When you walk up stairs or take a walk, do you ever have to stop becdause of pain in your chest, shortness of breath, or being very tired?.....YES NO
8. Do your ankles swell during the day?.....YES NO
9. Do you use more than 2 pillows to sleep?.....YES NO
10. Have you lost or gained more than 10 pounds in the past year?.....YES NO
11. Do you ever wake up from sleep and feel short of breath?.....YES NO
12. Are you on a special diet?.....YES NO
13. Has your medical doctor ever said you have cancer or tumor?.....YES NO
14. Do you have difficulty breathing at night .....Y N are you an active snorer?.....YES NO
15. Do you or have you had any disease, condition or problem not listed?.....YES NO
    If so, please list_____

For Women only: Are you pregnant?____What month?____Are you nursing?_____Taking birth control pills?_____

Consent:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. I authorize the doctors, hygienists and assistants to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by my doctor to make a thorough diagnosis of my dental needs.
3. I also authorize the doctor(s) to perform all recommended treatment mutually agreed upon by me and to use the appropriate medications and therapies indicated for such treatment in connection with (name of patient)_____. I understand that there are certain risks involved in all treatments and the use of all types of medications. Furthermore, I authorize and consent that the doctor(s) choose and employ such assistance as deemed fit to provide recommended treatment.
4. Lastly, I understand that all responsibility for payment for dental services provided in this office for me or my dependents is mine. The amount not covered by insurance is due and payable at the time services are rendered unless other arrangements have been made. Anything owed by insurance over 45 days becomes my responsibility and must be paid by the due date. In the event payments are not received by the agreed upon dates, I understand that a 2% finance charge per month (24% APR) will be added to my account. My payment must be received by the due date on the statement to avoid a $15 late payment fee.

Patient_____Date_____Witness_____

Parent or Responsible Party_____Relationship to Patient_____