

FOR OFFICE USE ONLY  
Chart Number \_\_\_\_\_

# Patient Registration

PREFERRED CONTACT METHOD  
(SELECT ALL THAT APPLY)  
 WORK  CELL  E-MAIL  HOME  
 MORNING  AFTERNOON

**TODAY'S DATE** \_\_\_\_\_ **Mayo Clinic #** \_\_\_\_\_

Patient Name \_\_\_\_\_ Sex  Male  Female Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Please select one:  Married  Single Social Security Number \_\_\_\_\_ Work Phone \_\_\_\_\_

Driver's License Number \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

If student, name of school \_\_\_\_\_

If a new patient, how did you hear of our office? \_\_\_\_\_

Wife's name or mother's name if patient is a minor \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employed by \_\_\_\_\_ Work Phone \_\_\_\_\_

Husband's name or father's name if patient is a minor \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employed by \_\_\_\_\_ Work Phone \_\_\_\_\_

## Health History

1. Have you ever taken Bisphosphonates such as Actonel, Boniva, or Fosamax? Yes or No
2. Are you under the care of a physician? Yes or No  
If yes, what for? \_\_\_\_\_
3. Are you currently taking any **prescription or non prescription** drugs or medications? Yes or No  
Names of medications \_\_\_\_\_
4. Do you have any form of Heart condition? ( If yes, please circle.) Yes or No  
(rheumatic fever, heart murmur, heart attack, pacemaker, congenital heart lesions, artificial valves, high blood pressure, mitral valve prolapse, etc).If other, please list \_\_\_\_\_
5. Have you any history of hepatitis, diabetes, asthma, cold sores, canker sore, cancer, stroke, tuberculosis, seizures, fainting spells, STD's, Aids, Herpes? (If Yes, Please Circle) Yes or No
6. Have you had any Hip or Joint replacement or any type of implants? Yes or No
7. Have you had any other serious illnesses? (If Yes, Please List) \_\_\_\_\_ Yes or No
- 8.( Adult Female) Are you now pregnant? Yes Or No Due Date \_\_\_\_\_
9. Do you have any allergies? Yes or No  
If Yes, List \_\_\_\_\_

## Financial Agreement and Authorization for Treatment

I certify that I understand that payment is due and payable at time of service. If I waive this option, a finance charge of 1.25% per month (15% APR) will be assessed on any outstanding balances beyond 60 days. I accept responsibility for any fees deemed necessary by Kasson Dental Clinic, LTD to collect this account including, but not limited to, attorney fees, court cost and collection fees. We reserve the right to charge for failed appointments, which are not cancelled in advance.

SIGNATURE (if under 18 Parent or Guardian) \_\_\_\_\_ Date \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If under 18 Parent or Guardian)

**Name of nearest friend or relative (not at the same address) in case of emergency:**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Dental Insurance

**CARRIER NO 1:**

Policy Holder's Signature \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Sec No. \_\_\_\_\_

Ins Company Name \_\_\_\_\_ Group No. \_\_\_\_\_

Ins Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Ins Company Phone No. \_\_\_\_\_

**CARRIER NO 2:**

Policy Holder's Signature \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Sec No. \_\_\_\_\_

Ins Company Name \_\_\_\_\_ Group No. \_\_\_\_\_

Ins Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Ins Company Phone No. \_\_\_\_\_