PATIENT REGISTRATION

Today's Date ____________________ Home Phone: ____________________

Cell Phone: ____________________

Patient: ____

Last Name First Name MI Preferred Name

If minor, Parents' Names ____

Address: ______________________________ City ____________________ ZIP __________

Sex: M ______ F ______ Date of Birth ____________ Single____Married____Widowed____Other

Patient/Parent Employed By ____

Title/Occupation ______________________________ Work Phone ____________________

Work Address: ____

Spouse/Parent Employed By ____

Title/Occupation ______________________________ Work Phone ____________________

Work Address: ____

Insurance ______________________________ Insured ____________________ DOB __________

Patient/Parent SSN ______________________________ Spouse/Parent SSN ____________________

Patient/Parent DL# ______________________________ Spouse/Parent DL# ____________________

In case of emergency, who should be notified ______________________________ Phone: ____________________

WELCOME TO OUR PRACTICE! IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE FEEL FREE TO ASK US.

Whom may we thank for referring you? ____

David W. Wright DDS, PC
3615 W. Park Row
Arlington, Texas 76013
817-261-8414

OFFICE FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, chaecks and most credit cards. We will be happy to help you process your insurance claim form if you will provide us with a completed form, and/or proof of dental insurance coverage.

Returned checks and balances older than 30 days will be subject to additional collection fees and interest charges. If it becomes necessary to turn an account over for collection, any collection fees will be added to the balance due. Charges will also be made for broken appointments and appointments canceled with less than 24 hours notice.

We will gladley discuss your proposed treatment and answer any questions you may have regarding treatment and fees. we must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance calims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems do arise, and we encourage you to contact us promptly for assistance in the management of your account.

When we do take assignment on policy, the portion not covered by insurance is due at the time of service. We can only accept assignments on insurance we are able to verify. This may mean that the first visit is paid by you in full and your insurance company will then reimburse you directly.

If you have any questions about the above information, please do not hesitate to ask. W are here to help you.

Please sign and date:

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS POLICY

____

Signature **Date**

DENTAL HEALTH HISTORY

Confidential

Today's Date____________________

Patient Name____ Birthday____________________

Last First Initial

DENTAL HISTORY

Reason for Today's Visit:____________________ Date of last dental care:____________________

Former Dentist:____________________ Date of last dental X-rays____________________

Address____

Check (✓) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivityto sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?____________________ How often do you brush?____________________

MEDICAL HISTORY

Physician's Name____________________ Date of Last Visit____________________

Have you had any serious illnesses or operations?__________ If yes, describe____________________

Have you ever had a blood transfusion? _____Yes _____No If yes, give approximate date____________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine),Pondimin (fenfluramine) and Redux (dexfenfluramine)___Yes___No

(Women) Are you pregnant? ___ Yes___No Nursing?___ Yes ___No Taking birth control pills? ___ Yes ___ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking :

____

____

____

____

____

Pharmacy Name:

Phone:

ALLERGIES

- ☐ Asprin
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex____________________
- ☐ Other____________________

____

____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/he staff responsible for any errors or omissions that I may have made In the completion of this form.

Date:____________________ Signature:____________________

(Signature of Patient, Parent, Guardian or Personal Representative)

Date:____________________ Signature:____________________

Annual Medical Updates (to be filled at future appointments)

Annual Medical Updates

HAS THERE BEEN ANY CHANGE IN YOUR HEALTH SINCE YOUR LAST DENTAL APPOINTMENT? YES _____ NO_______

FOR WHAT CONDITIONS?____

ARE YOU TAKING ANY NEW MEDICATIONS?________IF SO, WHAT____

DATE SIGNATURE

DATE DOCTOR'S SIGNATURE

Annual Medical Updates

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