Parker Family Dental
Health History and Registration

Patient's Name _____ Sex: M F Birth Date _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Please Circle One: Single, Married, Separated, Divorced, Widowed Occupation _____ Social Security # _____

Your Employer _____ Email Address _____ Home Phone _____

Person Responsible For Account _____ Work Phone _____

Referred to Us By _____ Best Phone # to Confirm Appts. _____ Cell Phone _____

Insurance Section

INSURANCE COMPANY NAME/ INSURANCE/PHONE	RELATIONSHIP TO EMPLOYEE ☐SELF ☐CHILD ☐SPOUSE ☐OTHER _____	ADDRESS TO SEND CLAIM TO:	IF FULL TIME STUDENT SCHOOL CITY	
EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS	EMPLOYEE/SUBSCRIBER SOC SEC NUMBER	EMPLOYEE/SUBSCRIBER BIRTHDATE MM DD YYYY	EMPLOYER (COMPANY) NAME AND ADDRESS	GROUP NUMBER
IS PATIENT COVERED BY ANOTHER PLAN OF DENTAL BENEFITS?				

PLEASE DRAW A CIRCLE AROUND ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE PRESENTLY.

Heart Disease or Condition	Rheumatic Fever	Asthma	Hepatitis	Venereal Disease
Angina Pectoris	Stroke	Hay Fever	Thyroid Disease	*(Herpes, Syphilis, Gonorrhea)*
Frequent Chest Pains	Hemophilia	Emphysema	Glaucoma	Drug Addiction
High Blood Pressure	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures	Psychiatric Treatment
Shortness of Breath	Prolonged or Unusual bleeding	Diabetes	Fainting or Dizzy Spells	Cancer
Swollen Ankles	Anemia	Ulcers	AIDS or AIDS Related Complex	Radiation Therapy
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive	Chemotherapy
Congenital Heart Disease	Sickle Cell Disease	Liver Disease	Cold Sores	Implant Prosthesis
Heart Murmur	Arthritis	Jaundice (Other Than Birth)	Oral Herpes	Unexplained Weight Loss

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. *(If in doubt, circle yes.)*
(If yes, please give details.) CONTINUE COMMENTS ON BACK IF NECESSARY.

1. HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE LAST YEAR?	Yes	No
2. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS? PLEASE LIST:	Yes	No
3. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS? PLEASE LIST:	Yes	No
4. HAVE YOU EVER BEEN TOLD YOU HAVE A HEART MURMUR OR BEEN SEEN BY A CARDIOLOGIST?	Yes	No
5. HAVE YOU EVER EXPERIENCED A COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT?	Yes	No
6. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE?	Yes	No
7. HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?	Yes	No
8. DO YOU USE TOBACCO PRODUCTS OR RECREATIONAL DRUGS? Cigarettes Cigars Pipes Chewing Tobacco Snuff or "Dip" Other Frequency	Yes	No
9. WOMEN: ARE YOU PREGNANT? (If yes, Please circle trimester) 1 2 3	Yes	No

I authorize Michael D. Petersen, D.D.S. to submit claims for payment of services to the health care service plans or insurance companies named above, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me. You are liable for payment for services rendered. This office has no obligation to assist you in obtaining payment of all or part of your bill from the insurance. Any portion of any bill for services rendered not paid by the insurance is your responsibility. Any bill not paid within 30 days of date due, the balance will accrue interest which you agree to pay at 18-21% per year compounded annually. You agree to pay all collection costs and attorney fees for the unpaid balance. If a law suit is commenced against you, you agree venue is proper in the courts of Douglas County, Colorado.

_____
Signature of Patient, Parent or Guardian Date:

_____
Dentist Signature