



PATIENT REGISTRATION

Date: _____

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

PREFERRED NAME: _____

Address: _____

City: _____ State / Zip: _____

E-Mail: _____

Cell: _____ Home: _____

Work: _____ Ext / Other _____

Sex: Male Female Age: _____

Birth Date: _____

Soc. Sec. #: _____ - _____ - _____

Drivers Lic.: _____

Where do you prefer to receive calls? Cell Home Work

Referred By

For Office Use Only Nicholas Coverage Care Credit Account #:

RESPONSIBLE PARTY (if someone other than the patient)

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

Address: _____

City: _____ State / Zip: _____

E-Mail: _____

Cell: _____ Home: _____

Work: _____ Ext: _____

Where do you prefer to receive calls? Cell Home Work

Relationship to Patient: _____

Sex: Male Female Age: _____

Birth Date: _____

Soc. Sec. #: _____ - _____ - _____

Drivers Lic.: _____

INSURANCE INFORMATION

Primary

Secondary

Name of Policy Holder: _____

Soc. Sec. #: _____ - _____ - _____ D.O.B. _____

Employer: _____

Insurance Co.: _____

Group #: _____ ID #: _____

Ins. Co. Address: _____

City: _____ State / Zip: _____

Phone: _____

Name of Policy Holder: _____

Soc. Sec. #: _____ - _____ - _____ D.O.B. _____

Employer: _____

Insurance Co.: _____

Group #: _____ ID #: _____

Ins. Co. Address: _____

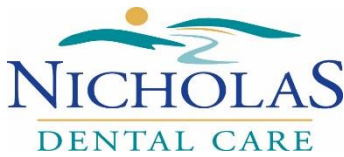
City: _____ State / Zip: _____

Phone: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Nicholas Dental Care Notice of Privacy Practices.

Patient, Parent or Guardian Name: _____ Signature: _____ Date: _____



MEDICAL HISTORY

Date: _____

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

PREFERRED NAME: _____ Sex: Male Female Birth Date: _____ Age: _____

• Are you under medical treatment now? Yes No If yes _____

• Are you taking any medications? Yes No If yes _____

• Have you been hospitalized for any major illness or surgery? Yes No If yes _____

• Have you had any serious head or neck injury? Yes No If yes _____

• Have you been diagnosed with Osteoporosis? Yes No If yes _____

• Are you taking any medication for Osteoporosis? Yes No If yes _____

• Do you use controlled substances? Yes No If yes _____

• Do you use tobacco? Yes No

• Do you use alcohol? Yes No

Women Only: Please check all that applies
Are you... Taking oral contraceptives?
 Pregnant? Trying to get pregnant? Nursing?

Office Use Only N20
Pre-Med with _____
Signature of Dentist _____ Date _____

Are you allergic to any of the following? Latex Aspirin Penicillin
 Codeine Sulfa Drugs Iodine Metal Local Anesthetics
 Other _____

Primary Care Physician Name/ Phone _____

- AIDS/ HIV Positive Yes No
Alzheimer's Disease Yes No
Anaphylaxis Yes No
Anemia Yes No
Angina Yes No
Arthritis/ Gout Yes No
Artificial heart Valve Yes No
Artificial Joint / Other Part Yes No
Asthma Yes No
Bruise Easily Yes No
Cancer Yes No
Chemotherapy Yes No
Chest Pains Yes No
Cold Sores/ Fever Blisters Yes No
Yellow Jaundice Yes No
Depression Yes No
Diabetes Yes No
Drug Addiction Yes No
Easily Winded Yes No
Emphysema Yes No
Epilepsy or Seizures Yes No
Fainting Spells/ Dizziness Yes No
Frequent Cough Yes No
Frequent Headaches Yes No
Genital Herpes Yes No
Glaucoma Yes No
Heart Attack/ Failure Yes No
Heart Murmur Yes No
Heart Pacemaker Yes No
Heart Trouble/ Disease Yes No
Hemophilia Yes No
Hepatitis A Yes No
Hepatitis B or C Yes No
Herpes Yes No
High Blood Pressure Yes No
High Cholesterol Yes No
Hives or Rash Yes No
Kidney Problem Yes No
Leukemia Yes No
Lyme Disease Yes No
Liver Disease Yes No
Lung Disease Yes No
Pain in Jaw Joints Yes No
Psychiatric Care Yes No
Radiation Treatment Yes No
Recent Weight Loss Yes No
Renal Dialysis Yes No
Rheumatism Yes No
Shingles Yes No
Sickle Cell Disease Yes No
Sinus Trouble Yes No
Stomach/ Intestinal Disease Yes No
Stroke Yes No
Thyroid Disease Yes No
Tuberculosis Yes No
Tumors or Growths Yes No
Ulcers Yes No
Venereal Disease / Which Yes No

• Have you ever had any other serious illness not listed? Yes No If yes _____

Authorization & Release

I authorize Nicholas Dental Care to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and /or other health practitioners.

I authorize and request my insurance company to pay directly to the dental office insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient, Parent or Guardian Name: _____ Signature: _____ Date: _____

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 2.5% on the balance owed will be assessed each month.

I realize that failure to keep this account current may result in Nicholas Dental Care being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services.

In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Patient, Parent or Guardian Name: _____ Signature: _____ Date: _____

Our mission is to serve our patients by providing exceptional dental care in a comfortable friendly environment.