

MEDICAL AND DENTAL HISTORY

Date of Birth: _____ Age _____ Date of Last Health Care Examination _____

For What _____

Have you been hospitalized in last 5 years? _____ If so, for what _____

Do you have or have you ever had	YES	NO		YES	NO
ANEMIA	_____	_____	A.I.D.S.	_____	_____
DIABETES	_____	_____	ABNORMAL BLOOD PRESURE	_____	_____
EPILEPSY	_____	_____	S _____/D_____/_____		
HEPATITIS	_____	_____	ARE YOU ALLERGIC TO:		
RHEUMATIC FEVER	_____	_____	PENICILLIN	_____	_____
HEART MURMUR	_____	_____	LOCAL ANESTHETIC	_____	_____
ABNORMAL HEART CONDITION	_____	_____	MEDICATION OR DRUGS	_____	_____
ABNORMAL BLEEDING FROM A CUT	_____	_____	WOMEN: ARE YOU PREGNANT	_____	_____
VENEREAL DISEASE	_____	_____			

If Allergic to Medications or Drugs, indicate which ones _____

Are you taking any medication _____ If so, for what _____

Other physical conditions _____

Name of your physician _____ Phone _____

Are you receiving care now _____ If so, nature of care _____

Are you now receiving other Health Care? Yes ☐ No ☐

IF SO, NATURE OF CARE NAME OF DOCTOR PHONE

May we request your health records? Yes ☐ No ☐

To whom should we address request _____

This information was given by _____



WELCOME TO OUR OFFICE

ENGLAND DENTAL CENTRE

ROGER W. ENGLAND, D.D.S.

1239 E. 4th St. Suite B Seymour, IN 47274
812-519-5457

ALL INFORMATION BELOW IS NECESSARY TO PROVIDE YOU WITH THE UTMOST CARE

REGISTRATION HISTORY

Date _____

Patient's Name _____ Patient Birthdate: _____ Single: _____
Name of Spouse: _____ Spouses Birthdate: _____ Widowed: _____
If a child, Parent's name: _____ Birthdate: _____ Married: _____
Divorced: _____
Separated: _____

Street Address: _____ S.S.# _____ - _____ - _____

City: _____ State: _____ Zip: _____ Phone #: _____ Cell Phone #: _____

Patient Employed By: _____ Bus. Phone #: _____ Cell Phone #: _____

Business Address: _____

Present Position: _____ How Long Held: _____

Spouse Employed By: _____ Business Phone #: _____

Business Address: _____

Present Position: _____

PURPOSE OF THIS APPOINTMENT: _____

Nearest friend or relative: _____

Relationship to Patient: _____ Phone #: _____

In case of emergency, whom should be notified: _____ Phone #: _____

Whom may we thank for referring you? _____

Method of Payment: CASH _____ CHECK _____ CREDIT CARD _____ (MC/VISA)

INSURANCE INFORMATION

Company: _____ ID #: _____

Member: _____ Birthdate: _____ Group #: _____

Fees for dental services are due and payable when services are rendered, regardless of insurance coverage, unless prior arrangements have been made. Any amount not paid within 30 days of the date of service will accrue interest charges and a monthly re-billing fee of \$3.00. Interest accrues at a periodic rate of 1.5% per month (or a minimum of \$3.00), which is an annual percentage rate of 18%. In the case of default of payment, patient and/or guardian is obligated to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

I have read and understood the above. My signature indicates acknowledgement and agreement of the above.

Signature of Patient or Parent Requesting Care

Date