KISS DENTAL CARE
425 Robinson Avenue
Newburgh, NY 12550

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PATIENT REGISTRATION FORM

PATIENT'S INFORMATION

Date:_____ Home Phone#:_____

Name:_____ SS#:_____

Address:_____ Apt#:_____

City: _____ State:_____ Zip:_____

Sex: [] M []F Age:_____ Birthdate:_____

Marital Status: [] Single [] Married [] Widowed [] Separated [] Divorced

Patient Employed By:_____ Occupation:_____

Business Address:_____ Business Phone#:_____

E-Mail Address: _____ Cell Phone #:_____

Preferred Pharmacy & Town: _____ Pharmacy Phone#:_____

Primary Physician & Phone#:_____ Referred By:_____

Name, Alternate Phone# & Relation of Emergency Contact:_____

Name of Person Responsible for Account:_____

Primary Dental Insurance: Name of Person Holding Ins:_____

Relation to Subscriber: []Self []Spouse []Child []Other_____ Birthdate:_____ SS#:_____

Address (if different from above):_____Phone#:_____

City:_____ State:_____ Zip Code:_____

Employed By: _____Occupation:_____

Business Address:_____Phone#:_____

Insurance Carrier:_____

Policy/Group #:_____ Subscriber/ID#:_____

Secondary Dental Insurance: Name of Person Holding 2nd Ins:_____

Relation to Subscriber: []Self []Spouse []Child []Other_____ Birthdate:_____ SS#:_____

Address (if different from above):_____Phone#:_____

City:_____ State:_____ Zip Code:_____

Employed By: _____Occupation:_____

Business Address:_____Phone#:_____

Insurance Carrier:_____

Policy/Group #:_____ Subscriber/ID#:_____

Please Complete Back of Page

Dental History

Former Dentist: _____
City, State: _____
Date of Last Dental Visit: _____

Date of Last X-Rays: _____
How Often Do You Floss? : _____
How Often Do You Brush? : _____

Medical History

Please check YES or NO for all questions in this section (#1 – 9):

	YES	NO
1. Are you currently under medical treatment?		
2. Have you ever had any serious illnesses or operations?		
3. Are you currently taking any medications? (Including OTC ie: baby aspirin) If YES, **Please Specify:**		
4. Do you smoke (tobacco or recreational)?		
5. Do you use alcohol regularly? (more than twice a week)		
6. Do you use chewing tobacco?		
7. (Women Only) Are You: Pregnant?		
Nursing?		
Taking Birth Control?		

	YES	NO
8. Have you ever had an allergy or sensitivity to:		
Local Anesthetic (ie. novocaine)		
Any Antibiotics (Please specify below) _____		
Sulfa Drugs		
Barbiturates (sleeping pills)		
Aspirin		
Sedatives		
Iodine		
Latex		
Other (Please specify below) _____		
9. Have you ever been told by a physician that you need to premedicate with antibiotics? **If so, for what?** _____		

Please check all that apply: (Including anything being controlled by medications, ie. HBP)
(Only mark if "YES")

Abnormal Bleeding (with extractions or surgery)	
AIDS	
Anemia	
Arthritis, Rheumatism	
Artificial Heart Valve	
Artificial Joints /Any "Replacements"	
Asthma	
Back Problems	
Blood Disease	
Cancer	
Chemical Dependency	
Chemotherapy	
Chronic Fatigue Syndrome	
Circulatory Problems	
Congenital Heart Lesions	
Cortisone Treatments	
Cough – persistent or bloody	
Diabetes	

Dialysis	
Emphysema	
Epilepsy	
Fainting or Dizziness	
Glaucoma / Cataract	
Headaches	
Heart Murmur	
Heart Problems	
Hepatitis - Type { }	
Herpes	
High Blood Pressure	
HIV Positive	
Jaundice	
Kidney Disease	
Liver Disease	
Low Blood Pressure	
Mitral Valve Prolapse	
Nervous Problems/Anxiety	

Pacemaker	
Psychiatric Care	
Radiation Treatment	
Respiratory Disease	
Rheumatic Fever	
Scarlet Fever	
Sinus Trouble	
Stroke / TIA	
Swelling of Feet/Ankles	
Swollen Neck Glands	
Thyroid Problems	
Tuberculosis	
Tumor/ Growth on head or neck	
Ulcers	
Venereal Disease / STD's	
Vertigo	
OTHER- **Please specify:**	

Assignment and Release

I hereby authorize payment directly to KISS DENTAL CARE. for all insurance benefits otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.*** I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Divorce Cases: In the case of divorce, the individual who receives the care is responsible of their own co-pays, coinsurance, and non-participating insurance balances at the time of service regardless of who holds the insurance coverage. We will not bill the divorced spouse for the patient's services.

Child Custody Cases: The parent with the primary custody is usually the parent with whom the child lives and is typically the one bringing the child to the practice for care. The custodial parent is held responsible for all payments due whether the account is self pay, participating insurance or non-participating insurance. If the non-custodial parent carries the insurance on the child, the office will bill that insurance company although co pays will still be billed to the custodial parent. The practice **does not get involved** with divorce specifics (ie: one parent pays 80%, the other pays 20%) and it is the responsibility of the parents to work out an agreement among themselves outside of the office or through the court system prior to treatment.

Insurance/Deductible: The patient is expected to present a valid insurance card at each visit. It is your responsibility to either have it with you or be prepared to provide payment of services in full at the time of visit. All past due balances and deductibles are expected at the time of service. If you do not have an insurance card, you must have documented proof of insurance whether from the carrier or your human resources department before being seen.

Signature of Responsible Party _____ Date _____