James Rore DDS
Family, Implant & Sedation Dentistry

Patient Registration Form

ABOUT YOU

Today's Date _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed

Patient Name _____ Date of Birth _____/_____/_____

If a child, Guardian(s) name _____Social Security # _____

Home Phone _____ Cell Phone _____

Street Address _____ City _____ State ___ Zip _____

DL # _____ Email _____

Employer: _____ Occupation _____

How did you hear about our office? _____

Emergency Contact

Name _____ Relationship _____Phone_____

INSURANCE INFORMATION

Primary Insurance

Insurance Co Name: _____ Insurance Co Phone Number _____

ID # _____ Group # _____

Insurance Subscriber Name _____ Relationship _____

Subscriber Social Security # _____ Subscriber Date of Birth _____

Secondary Insurance

Insurance Co Name: _____ Insurance Co Phone Number _____

ID # _____ Group # _____

Insurance Subscriber Name _____ Relationship _____

Subscriber Social Security # _____ Subscriber Date of Birth _____

DENTAL HISTORY

Reason for this visit? _____

When was your last dental visit? _____ Have you had x-rays taken in the last year? _____

Name of your last dentist _____

May we request x-rays & records from your previous Dentist? _____

Do you have or have you had any dental complications? _____

HEALTH HISTORY

Name & contact number of Physician _____

Date of last Health Care Examination: _____May we request your Health Records? ☐ Yes ☐ No

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If yes, for what? _____

Are you in good health? ☐ Yes ☐ No

(**Female patients**) Are you pregnant? ☐ Yes ☐ No

Have you ever taken Phen-Fen, Fosamax or any other medications for osteoporosis or osteopenia? ☐ Yes ☐ No

Do you have any **current** medical treatment, **impending** operations, or **any other medical or dental information** that may possibly affect your dental treatment? _____

HEALTH HISTORY CONTINUED....

Do you have or have you ever had:

	YES	NO		YES	NO
Osteoporosis or Osteopenia	☐	☐	Breast Implants	☐	☐
Any Heart Problems	☐	☐	Artificial Joint replacement	☐	☐
Thyroid Disorders	☐	☐	Hepatitis	☐	☐
Sinus Problems	☐	☐	High Blood Pressure	☐	☐
Pacemaker	☐	☐	Low Blood Pressure	☐	☐
Herpes	☐	☐	Stroke	☐	☐
Malignancies	☐	☐	Typhoid Fever	☐	☐
Circulatory Problems	☐	☐	Measles	☐	☐
Tonsillitis	☐	☐	Nervous Disorders	☐	☐
Anemia	☐	☐	Mumps	☐	☐
Tuberculosis	☐	☐	Radiation Treatments	☐	☐
Arthritis	☐	☐	Psychiatric Care	☐	☐
Ulcer	☐	☐	Excessive Bleeding Disorders	☐	☐
Asthma	☐	☐	Rheumatic Fever	☐	☐
Venereal Disease	☐	☐	Diabetes	☐	☐
HIV	☐	☐	Scarlet fever	☐	☐
AIDS	☐	☐	Artificial Valves	☐	☐
Allergies to Latex	☐	☐	Autoimmune Disorders	☐	☐
Allergies to Anesthetics	☐	☐	Seizure Disorders	☐	☐
History of Substance Abuse	☐	☐	Do you have any relevant family history?	☐	☐

MEDICATIONS

If you are taking any medications, drugs including over-the counter and herbal supplements please list below;_____

_____

_____

_____

_____

ALLERGIES

If you are allergic to any medications, drugs or materials please list below;_____

_____

_____

_____

_____

OFFICE POLICIES

- **Cancellations** – If it is necessary to cancel, re-schedule or change an appointment reserved for you, our office asks for a **minimum of 24 hour business notice**. If it is not possible to give us this notice a cancellation fee will be assessed.
- **Financial/Insurance** – I hereby authorize payment directly to James Rore DDS of the group insurance benefits otherwise payable to me. I understand my insurance is being billed only as a courtesy to me. Any amount not covered by the insurance is my full responsibility.
- **Dental Treatment Consent** – I, the undersigned, hereby authorize James Rore DDS to take radiographs, study models, photographs or any other diagnostic aids he deems appropriate to make a thorough diagnosis of my dental needs. I authorize James Rore DDS to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that James Rore DDS employ any such assistants as he deems appropriate to my care. I authorize Dr. James Rore to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

By signing below, I understand the above information and guarantee this form was completed to the best of my knowledge. I understand it is my responsibility to inform the office of James Rore DDS of any further changes to the information I have provided.

_____

Patient/Guardian Signature **Date**

OFFICE USE: **BP** _____/_____

Doctor Signature: _____ Date: _____