

EMERGENCY REGISTRATION FORM

Name:		Birth date:	
Address:			
City:	State:	Zip:	
Home Phone:		Social Security No.:	
Employer:		Business Phone:	
E-mail address:			

Person Responsible for the account:			
Address:			
City:	State:	Zip:	
Home Phone:		Social Security No.:	

Do you have dental insurance?		Yes () / No ()	
Name of Insurance Plan:			
Whom may we thank for referring you?			

Nature of the Emergency?

MEDICAL HISTORY

1.	Do you have a current medical problem?	Yes ()	No ()
>> Details:			
2.	Do you have heart trouble?	Yes ()	No ()
>> Details:			
3.	Have you had rheumatic fever?	Yes ()	No ()
>> Details:			
4.	Do you have high blood pressure?	Yes ()	No ()
>> Details:			
5.	Do you frequently wake up with a headache?	Yes ()	No ()
>> Details:			
6.	Are you taking any kind of medication now?	Yes ()	No ()
>> What?			
7.	Are you sensitive or allergic to anything?	Yes ()	No ()
>> What?			
8.	Have you tested positive for the HIV virus?	Yes ()	No ()
>> Details:			
9.	Have you ever been hospitalized?	Yes ()	No ()
>> Details:			
10.	Do you have or have you had any problem with any of the following:		
	Asthma?	Yes ()	No ()
	Venereal Disease?	Yes ()	No ()
	Ulcers?	Yes ()	No ()
	Epilepsy?	Yes ()	No ()
	Injury to face?	Yes ()	No ()
	Blood Disorders?	Yes ()	No ()
	Infectious Hepatitis?	Yes ()	No ()
	Tuberculosis?	Yes ()	No ()
	Cancer?	Yes ()	No ()
	Diabetes?	Yes ()	No ()
For women:			
11.	Are you pregnant?	Yes ()	No ()
>> Expected delivery date:			
Is there any other information that should be known about your health?			
Please provide me with the following type of treatment: (check one)			
A.	Best modern dentistry has to offer	()	
B.	Best, but on a somewhat limited budget	()	
C.	Best, but finances are a major concern and limiting factor	()	
D.	Best, but keep me out of pain. Fear is my major concern	()	
E.	Best, but please get me out of pain. I'll see you the next time something hurts	()	

	Is there anything you don't like about the appearance of your teeth or the way they affect your smile?	Yes ()	No ()
>> Details:			

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF THE DENTAL AND ORAL SURGERY PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE AND WILL ASSUME RESPONSIBILITIES FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

IN THE EVENT A MEMBER OF THE DENTAL STAFF IS ACCIDENTALLY INJURED BY A SHARP OBJECT THAT HAS BEEN EXPOSED TO THE PATIENTS SALIVA OR BLOOD, THE PATIENT WILL BE REQUESTED TO BE TESTED FOR HEPATITIS B AND THE HIV VIRUS. THIS WILL BE DONE AT A LOCATION WHERE THE APPROPRIATE PRETEST COUNSELING IS AVAILABLE. THE TEST WILL BE DONE AT NO CHARGE TO THE PATIENT.

SIGNATURE:	DATE:
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