Kevin Mendez, D.D.S. & Associates, P.L.L.C

Patient Registration

Patient Registration

Today's Date _____

Sex M _____ F _____

Last Name _____

First Name _____ MI _____

Address _____

City, State, ZIP _____

Social Security # _____

E-mail _____

Home Phone _____

Cell Phone _____

Work Phone _____

Occupation _____

Employer _____

Date of Birth _____/_____/_____

Spouse Name _____

Responsible Party Information

Today's Date _____

Sex M _____ F _____

Last Name _____

First Name _____ MI _____

Address _____

City, State, ZIP _____

Social Security # _____

E-mail _____

Home Phone _____

Cell Phone _____

Work Phone _____

Occupation _____

Employer _____

Date of Birth _____/_____/_____

Spouse Name _____

Who can we thank for referring you to our office _____

Please provide to our staff a copy of:

* Your primary insurance card
* Your secondary insurance card
* Your Driver's license

IN CASE IF EMERGENCY NOTIFY:

Name _____
Home Phone _____
Cell Phone _____
Email _____

Please read carefully and sign:

All information on both sides of this form is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If I ever have any changes in my health,. medications currently taking , responsible party, Insurance coverage, or address or contact information, I will inform the office at the next dental appointment

I understand that I am financially responsible to the office of Kevin Mendez, D.D.S. & Associates, P.L.L.C. for .all charges incurred by myself and / or my dependents.. I understand that I will be responsible for any and all appropriate fees incurred by myself/ or my dependents, that are not covered by my Insurance policies. I also agree that if my dependents or I are not covered by an Insurance plan that I have represented to be valid, I will be responsible for all charges whether or not paid by said insurance.

I Agree that if my account becomes past due 45 days or more, I will pay interest on the past due balance at the rate of 1.5% per month (18 annually). I agree that in the event my account is past due 60 days or more from the date of service, and is referred to an attorney or collection agency for collection, I will be liable for up to one-third (1/3) of the total balance for collection/attorney's fees plus all court and collection costs.

I herby assign all medical, dental/ or surgical benefits to which I am entitled for any services rendered me/or my dependents by any doctor or professional in this office to Kevin Mendez D.D.S. & Associates, P.L.L.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I herby authorize assigns to release all information to secure payment.

SIGNATURE _____ DATE _____

It is import that I know about your Medical and Dental history. These facts have a direct bearing on your dental health and our provision of quality care for you. The information is strictly confidential and will not be released to anyone without your consent. Thank you for taking the time to completely fill out this questionnaire.

Medical History

Do you have any current health problems? Yes NO

Are you under a Physician's care? Yes NO

For What? _____

What medications are you currently taking? _____

_____

_____

What medications are you allergic to? _____

_____

Are you allergic to latex? Yes NO

Are you allergic to penicillin (amoxicillin)? Yes NO

What surgeries have you had in the past 5 years? Yes NO

Approximate dates? _____

_____

Do you have artificial joints? Yes NO

Do you need to take pre-medications for dental work? Yes NO

FOR WOMEN ONLY

Are you pregnant? Yes NO

If so, due date: _____

If so, are under physician's care? Yes NO

Are you nursing? Yes NO

Are you taking birth control pills? Yes NO

Dental History

Are you having dental pain? Yes NO

Is your present dental health poor? Yes NO

Do you wear dentures partial or fully? Yes NO

Do you have Missing teeth? Yes NO

Are you interested in replacing missing teeth? Yes NO

Are you apprehensive about dental care? Yes NO

Do your gums bleed when brushing? Yes NO

Have you ever been told you have TMJ? Yes NO

Do you think your teeth are "crooked"? Yes NO

Have you had orthodontics (braces)? Yes NO

Do you use cigars, cigarettes or chew? Yes NO

Do you like the color of your teeth? Yes NO

Are your teeth loose? Yes NO

Do you brush regularly? Yes NO

Date of last dental cleaning: _____

Date of last full month x-rays: _____

Other dental problems you would like to address? _____

_____

_____

Are you happy with your teeth? Yes NO

Have you seen a gum specialist in the past? Yes NO

Family Physician Name _____ **Phone** **Email** _____

Please rank the following in order in which they would keep you from having dental treatment:
(1 = most, 4 least)

Fear of pain (1) (2) (3) (4) lack of concern (1) (2) (3) (4) Cost of treatment (1) (2) (3) (4) Missing work time (1) (2) (3) (4)

Medical Condition

AIDS/HIV pos	Yes	NO	Emphysema	Yes	NO	Pacemaker surgery	Yes	NO
Anaphylaxis	Yes	NO	Fainting	Yes	NO	Psychiatric Care	Yes	NO
Anemia	Yes	NO	Glaucoma	Yes	NO	Radiation Treatment	Yes	NO
Artificial Heart Valves	Yes	NO	Heart Murmur	Yes	NO	Rheumatic/scarlet fever	Yes	NO
Asthma	Yes	NO	Heart problems	Yes	NO	Shortness of breath	Yes	NO
Artificial joints	Yes	NO	Herpes	Yes	NO	Spina Bifida	Yes	NO
Blood Disease	Yes	NO	Hepatitis A	Yes	NO	Stroke	Yes	NO
Cancer	Yes	NO	Hepatitis B	Yes	NO	Swelling (feet, Ankles)	Yes	NO
Chemical dependency	Yes	NO	Hepatitis C	Yes	NO	Thyroid disease	Yes	NO
Chemotherapy	Yes	NO	High Blood Pressure	Yes	NO	Tuberculosis	Yes	NO
Cortisone treatment	Yes	NO	Jaw pain	Yes	NO	Ulcerative Colitis	Yes	NO
Diabetes	Yes	NO	Kidney disease	Yes	NO	Venereal disease	Yes	NO
Epilepsy	Yes	NO	Liver Disease	Yes	NO	Other (discuss with Dentist)	Yes	NO
			Mitral Valve prolapse	Yes	NO			

SIGNATURE _____ DATE _____