Dr. Mary Berk-Mooney
Troy Dental Care

PATIENT REGISTRATION

TODAY'S DATE: _____

PATIENT'S NAME _____ DOB _____ AGE _____ SEX ❑ M ❑ F

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

PLEASE SELECT ONE: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ WIDOW YOUR SS# _____

YOUR EMPLOYER _____ OCCUPATION _____

ARE YOU A FULL TIME STUDENT: ❑ YES ❑ NO

IF PATIENT IS A MINOR WE NEED: MOTHER'S BIRTH DATE _____ FATHER'S BIRTH DATE _____

PERSON RESPONSIBLE FOR ACCOUNT _____ DRIVER'S LICENSE # _____

NAME OF SPOUSE (PARENT IF MINOR) _____ E-MAIL ADDRESS _____

SPOUSE (PARENT) EMPLOYER _____ SPOUSE'S SS # _____

WORK PHONE # _____ CELL PHONE # _____

EMERGENCY INFORMATION (A RELATIVE NOT LIVING WITH YOU)

NAME _____ RELATION _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

How did you hear about our office? _____

Reason for this visit? _____

Is there any other medical or dental information we should know about? _____

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

INSURED'S NAME _____

DOB _____ SS # _____

INSURED EMPLOYER _____

INSURANCE CO. _____

ADDRESS _____

CITY/ST./ZIP _____

PHONE # _____

GROUP # _____

LOCAL # _____

IF YOU HAVE DOUBLE INSURANCE COVERAGE, COMPLETE THIS FOR THE SECOND COVERAGE

INSURED'S NAME _____

DOB _____ SS # _____

INSURED EMPLOYER _____

INSURANCE CO. _____

ADDRESS _____

CITY/ST./ZIP _____

PHONE # _____

GROUP # _____

LOCAL # _____

PLEASE SIGN IN BOTH PLACES

ASSIGNMENT OF BENEFITS

I authorize payment directly to Dr. Mary Berk-Mooney of the group insurance benefits otherwise payable to me:

SIGNATURE X _____

RELEASE OF INFORMATION

I authorize the release of any information necessary to process my claim.

SIGNATURE X _____

MEDICAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

- ❑ Allergies (Seasonal)
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Diabetes
- ❑ Dizziness
- ❑ Drug Addiction
- ❑ Emphysema
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Heart Lesions (Congenital)
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Jaw Joint Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Phen Fen (1 month +)
- ❑ Radiation (head/neck)
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Seizures
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Venereal Diseases
- ❑ Other

FOR WOMEN ONLY

- ❑ Birth Control Pills
- ❑ Breast-feeding
- ❑ Pregnant
  - ❑ 1-3 months
  - ❑ 3-6 months
  - ❑ 6-9 months

DO YOU HAVE ANY OF THE FOLLOWING DRUG ALLERGIES?

- ❑ Aspirin
- ❑ Darvon
- ❑ Erythromycin
- ❑ Local Anesthetic
- ❑ Nitrous Oxide
- ❑ Penicillin
- ❑ Percodan
- ❑ Valium
- ❑ Other _____

_____

Family Physician _____

Phone # _____

Are you under a physician's care? ❑ Yes ❑ NO

What for? _____

Are you taking ANY medication? ❑ Yes ❑ NO

What kind? (Name & Strength)

_____

_____

_____

_____

_____

FINANCIAL INFORMATION

RETURN CHECK POLICY:

A $25.00 charge in addition to any bank fees, will be charged to your account.

DEFAULT POLICY:

In the case of default of payment, responsible party will pay any legal interest on the balance, together with any collection cost and reasonable Attorney fees incurred to effect collection on this account.

BROKEN APPOINTMENT POLICY:

24 hours notice is required for cancellation of an appointment or it will be considered a broken appointment. Appointment time is reserved exclusively for you, therefore if broken you will be charge an appropriate fee.

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

I understand the the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical or dental status.

Signature _____ Date _____