Welcome to our Office

Dr. Mary Purinsh
WESTSIDE FAMILY DENTISTRY, P.C.

REGISTRATION FORM

Section I: Patient Information

Date_____
Name:_____ I prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____Cell Phone (_____)_____
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

☐ Male ☐ Female Date of Birth: ____ ____ _____ Social Security Number:_____
Month Day Year

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____
Your Email Address_____ Whom may we thank for referring you? _____

Section II: Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____
Name:_____Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III: Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____
DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING
Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Group #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Section IV: Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Mary Purinsh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Responsible Party Signature_____ Date_____

Relationship to Patient_____

MEDICAL & DENTAL INFORMATION

Physicians :

Primary Care Doctor:	Date of Last Physical:
Address:	Office Phone#:
Other Physician(s):	
Are you currently under care or medical supervision? : ☐ Yes : ☐ No	

Allergies : Please check (☑) medicine and material allergies

☐ Aspirin	☐ Dental adhesives, metals, etc.	☐ Penicillin
☐ Barbiturates	☐ Iodine	☐ Sulfa
☐ Codeine	☐ Latex	☐ Other:
☐ Dental anesthetics	☐ Pain medications	
Details:		

Medications : Please list all medications and purpose for prescription.

Pharmacy name and location:

Health History: Check (☑) if you have had any of the following and give details.

☐ AIDS/HIV	☐ Cortisone treatments	☐ Kidney disease	☐ Swelling of ankles
☐ Anemia	☐ Persistent cough	☐ Liver disease	☐ Swollen neck glands
☐ Arthritis	☐ Diabetes	☐ Low blood pressure	☐ Thyroid problems
☐ Artificial heart valves	☐ Emphysema	☐ Mitral valve prolapse	☐ Tonsillitis
☐ Artificial joints	☐ Epilepsy	☐ Nerve problems	☐ Tuberculosis
☐ Asthma	☐ Fainting/dizziness	☐ Pacemaker	☐ Tumors head or neck
☐ Back problems	☐ Glaucoma	☐ Psychiatric care	☐ Ulcer
☐ Bleeding problems	☐ Headaches	☐ Radiation therapy	☐ Venereal disease
☐ Blood diseases	☐ Heart murmur	☐ Respiratory disease	☐ Weight loss - recent
☐ Cancer	☐ Heart problems	☐ Rheumatic fever	☐ Other
☐ Chemical dependent	☐ Hepatitis – Type____	☐ Scarlet fever	
☐ Chemotherapy	☐ Herpes	☐ Shortness of breath	Women:
☐ Circulatory problems	☐ High Blood Pressure	☐ Sinus trouble	☐ Pregnant
☐ Congenital heart	☐ Jaundice	☐ Skin rashes	☐ Birth control pills
☐ COPD	☐ Jaw pain	☐ Stroke	☐ Nursing
Have you had any surgeries in the past five years?	☐ Yes ☐ No	If yes, for what was the surgery ?	
Details of conditions checked and surgeries:			

Dental History: Check (☑) if you have any of the following concerns.

☐ Bad breath	☐ Grinding or clenching	☐ Sensitivity to cold
☐ Bleeding gums	☐ Gums hurt to brush	☐ Sensitivity to heat
☐ Bump or sore in mouth	☐ Jaw pain or tiredness	☐ Sensitivity to sweets
☐ Burning tongue feeling	☐ Lip or cheek biting	☐ Sensitivity when biting
☐ Chew on one side	☐ Loose teeth	☐ Smoke or use tobacco
☐ Cavity	☐ Mouth breathing	☐ Swelling in cheek or face
☐ Filling or tooth is broken	☐ Pain in front of ear	☐ Teeth injured in accident
☐ Food catches between teeth	☐ Periodontal (gum) disease	☐ Wisdom teeth

Last dental exam:	Date of last dental x-rays:	
Former dentist:	City/State:	
How often do you brush?	How often do you floss?	Have you had orthodontic treatment? ☐ Yes ☐No

The medical and dental information given above is true to the best of my knowledge.

Patient's or Responsible Party's Signature Date