



## PATIENT REGISTRATION

Patient's Name: \_\_\_\_\_ Patient's Birth Date: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Spouse's Birth Date: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Message #: \_\_\_\_\_  
Nearest Relative's name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Best Contact Method: By phone or Text? \_\_\_\_\_  
E-mail: \_\_\_\_\_

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**If you are covered by Insurance we will need the following:**

### INSURANCE INFORMATION

Patient's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Spouse's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
#1 Primary Name of Insured: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_ Address: \_\_\_\_\_  
Group #: \_\_\_\_\_ Local #: \_\_\_\_\_  
#2 Secondary Name of Insured: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_ Address: \_\_\_\_\_  
Group #: \_\_\_\_\_ Local #: \_\_\_\_\_

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### CREDIT INFORMATION

**Responsible Party:** \_\_\_\_\_

I hereby authorize Chardonnay Dental to perform dental services on the above named person. I am the patient / legal guardian.  
I agree to pay all fees on the date of service unless specific financial arrangements have been made. My signature below releases assignment of Insurance Benefits to Chardonnay Dental. In the event that legal action is brought to collect amount(s) owed to Chardonnay Dental, the prevailing party shall be entitled to the award of a reasonable attorney fee, and venue shall be in Benton County, Washington.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Office Use Only:**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Chief Dental Complaint: \_\_\_\_\_

Date of Last Dental Visit and X-rays: \_\_\_\_\_ Name of Medical Doctor: \_\_\_\_\_

Are you taking any medications at this time? Please list: \_\_\_\_\_

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**DO YOU HAVE A MEDICAL CONDITION THAT REQUIRES PRE-MEDICATION PRIOR TO DENTAL WORK?**

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**HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR:**

	No	Yes	Explain
Heart Disease including:			
Heart Murmur-----	_____	_____	_____
Rheumatic Fever-----	_____	_____	_____
Pace Maker-----	_____	_____	_____
Valve Replacement -----	_____	_____	_____
Heart Attack -----	_____	_____	_____
By-Pass Surgery-----	_____	_____	_____
Stroke-----	_____	_____	_____
Abnormal Blood Pressure----	_____	_____	_____
Ulcers-----	_____	_____	_____
Tuberculosis or Lung Disease-----	_____	_____	_____
Diabetes-----	_____	_____	_____
Anemia-----	_____	_____	_____
Cancer-----	_____	_____	_____
Venereal Disease-----	_____	_____	_____
Asthma or Hay Fever-----	_____	_____	_____
Hepatitis-----	_____	_____	_____
Arthritis-----	_____	_____	_____
Joint Replacement-----	_____	_____	_____
HIV positive (Aids)-----	_____	_____	_____
Cocaine or Street Drug User?-----	_____	_____	_____
Seizures-----	_____	_____	_____

**ARE YOU ALLERGIC TO:**

Penicillin-----	_____	_____	_____
Codeine-----	_____	_____	_____
Local Anesthesia-----	_____	_____	_____
Sulfa-----	_____	_____	_____
Latex-----	_____	_____	_____
Other Allergies? -----	_____	_____	_____

Are you subject to prolonged bleeding? \_\_\_\_\_

Are you pregnant? No \_\_\_\_\_ Yes \_\_\_\_\_ Date Due \_\_\_\_\_

**Other medical complications?**

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