Delbert Warner, D.D.S. P.C.
Whole Family Dental Care

Patient Registration and Health History Form

Our office is committed to exceeding the standard of infection control mandated by OSHA, the CDC and the ADA

Date: _____

Name: _____

Birthdate: _____ SSN#: _____

☐ Male ☐ Female ☐ Minor
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

Address: _____

City, State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Employer: _____

Spouse/Parent Name: _____ Phone: _____

Employer: _____

Responsible Party/Insured (person with insurance of person paying the bill)

FILL OUT THIS PORTION IF RESPONSIBLE PARTY IS SOMEONE OTHER THAN YOURSELF!

Name: _____

Relationship to patient: _____

Birthdate: _____ SS#: _____

Address: _____

City, State, ZIP: _____

Employer Address: _____ Work Phone: _____

Home Phone: _____

Cell Phone: _____ Emergency Contact: _____

Insurance Company: _____ Group #: _____

Phone: _____ Fax: _____

Address: _____

_____

How did you hear about us?

☐ Sign ☐ Yellow Pages ☐ Website ☐ Social Media: _____ ☐ Other: _____

Whom may we thank for referring you to our office? _____

If you are a new patient, please fill out this form and send it to florwarner@gmail.
Once we are able to verify your insurance, walk-ins are welcome. Please send in this form 24 hours prior.

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ☐ YES ☐ NO
   Physician's Name _____ Phone # _____
   Address _____
2. Are you now taking any medication, drugs or pills? ☐ YES ☐ NO
   If yes, please list: _____
3. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ☐ YES ☐ NO
   If yes, please list: _____
4. Indicate which of the following you have had or have at present.

Heart Disease or Attack ☐	Kidney Trouble ☐	Venereal Disease ☐
Angina Pectoris ☐	Ulcers ☐	A.I.D.S. ☐
Congenital Heart Disease ☐	Diabetes ☐	H.I.V. Positive ☐
Heart Murmur ☐	Thyroid Problems ☐	Cold Sores/Fever Blisters ☐
High Blood Pressure ☐	Glaucoma ☐	Blood Transfusion ☐
Arteriosclerosis ☐	Cosmetic Surgery ☐	Hemophilia ☐
Mitral Valve Prolapse ☐	Emphysema ☐	Anemia ☐
Artificial Heart Valve ☐	Chronic Cough ☐	Sickle Cell Disease ☐
Heart Pacemaker ☐	Tuberculosis ☐	Bruise Easily ☐
Heart Surgery ☐	Asthma ☐	Liver Disease ☐
Rheumatic Fever ☐	Hay Fever ☐	Yellow Jaundice ☐
Arthritis ☐	Allergies or Hives ☐	Epilepsy or Seizures ☐
Osteoperosis Medication ☐	Sinus Trouble ☐	Fainting or Dizzy Spells ☐
Cortisone Medicine ☐	Radiation Therapy ☐	Nervousness ☐
Drug Addiction ☐	Chemotherapy ☐	Psychiatric Treatment ☐
Stroke ☐	Hepatitis (infectious) ☐	Developmentally Disabled ☐
Artificial Joints (hip, knee, etc.) ☐	Hepatitis B (serum) ☐	Do You Snore ☐

5. Do you use tobacco in any form? ☐ YES ☐ NO ☐ Cigarettes _____ packs/day ☐ Chewing Tobacco
6. Do you have or have you had any disease, condition or problem not listed?
   If yes, please list: _____

FOR WOMEN ONLY:

7. Are you pregnant? ☐ YES, what month? _____ ☐ NO Are you nursing? ☐ YES ☐ NO Are you taking birth control? ☐ YES ☐ NO

DENTAL HISTORY

1. Are you having pain or discomfort at this time? ☐ YES ☐ NO
   If yes, please describe: _____
2. When was your last dental visit? _____
   For what? _____
3. Have you had a FULL MOUTH series of x-rays in the past 3 years? ☐ YES ☐ NO Date: _____
4. Have you received regular dental care in the past? ☐ YES ☐ NO
5. Are you happy with the appearance of your teeth? ☐ YES ☐ NO
6. Have you ever had an upsetting experience in a dental office? ☐ YES ☐ NO
   If yes, please describe: _____
7. Is there anything else about having dental treatment that bothers you? ☐ YES ☐ NO
   If yes, please describe: _____

Signature (Patient or Parent if minor) Date:

CONSENT

1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patients dental needs.

2 I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge * (18% APR) may be added to my account. I understand that the office may exchange account information with credit reporting agencies regarding any credit extended on my account.

Patient Signature Date: Witness:

Parent or Responsible Party Relationship to Patient