



Northwest Periodontics

Periodontal & Implant Dentistry
Dr. Stanley D. Halpern

New Patient Registration

Please complete the form below and bring to your first appointment.

Date _____

Last Name _____ First Name _____ Middle _____

Preferred Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell phone _____

Sex: M F Age _____ Date of Birth _____

Social Security # _____ - _____ - _____

Minor Married Single Divorced Widowed

Driver's License # _____

E-mail Address _____

Employer _____ Address _____ Occupation _____

Spouse/Parent Name _____ Date of Birth _____

Social Security # _____ - _____ - _____

Spouse Employer _____ Address _____

Business Phone _____

PATIENT: Dental Insurance Company _____

SPOUSE: Dental Insurance Company _____

Who is responsible for this account? _____

Relation to Patient _____

In Case of Emergency Call _____ Phone _____

Referring Doctor or Patient _____

Medical History

Physicians Name _____ Phone _____

Date of Last Physical _____

PLEASE CHECK BOXES THAT APPLY:

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever / MVP | <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatic Fever/MVP |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Allergies to Anesthetics/Drugs | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS-HIV | <input type="checkbox"/> Chemical Dependency/Treatment | <input type="checkbox"/> AIDS-HIV infraction |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Blood Dyscrasia | <input type="checkbox"/> Smoker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Pregnant / Nursing | <input type="checkbox"/> Venereal Disease |

ANY OTHER MEDICAL CONDITION - PLEASE LIST _____

Chemical Dependency/Treatment

Do you have any allergies ? Yes No

If yes what? _____

Have you ever responded adversely to medication or dental treatment? Yes No

If yes what? _____

Are you under the care of a physician? Yes No If yes, Who? _____

For what conditions? _____

Are you taking any medications? Please list. _____

Is there anything else we should know about your medical history?

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I understand that insurance coverage is a contract between my insurance carrier and myself. As a courtesy, Northwest Periodontics will submit all necessary information. After 60 days the balance is due and payable and will incur a 1.5 % monthly interest charge (18% per year).

Signature _____ Date _____

We accept most dental insurance plans. Please ask for the specific details of your insurance. Pre-treatment estimates are always available.