

Mike Pulido, D.D.S.

Patient Registration

(Please Print)

Patient Name: _____ Home Phone: _____
Last First M.I. Preferred Name

Street Address: _____ City: _____ State: _____ Zip: _____

Sex: _____ Age: _____ Birth Date: _____ / _____ / _____ Child Single Married Divorced Other
M/F M D Year

SSN# _____ - _____ - _____ Cell Phone: (_____) _____ - _____ Other Phone: (_____) _____ - _____

Employer: _____ Occupation: _____ How long Employed? _____

Business Address: _____ Business Phone: (_____) _____ - _____

If full-time student, list school name: _____

Who is responsible for this account? _____ Relationship to patient: _____

Spouse/Parent SSN# _____ - _____ - _____ Spouse/Parent Birth Date: _____ / _____ / _____
M D Year

Dental Insurance Co.: _____ Group # _____ Phone: (_____) _____ - _____

Name of Policy Holder: _____ SSN# _____ - _____ - _____ Birth Date: _____ / _____ / _____
M D Yr

Secondary Insurance Co.: _____ Group # _____ Phone: (_____) _____ - _____

Name of Policy Holder: _____ SSN# _____ - _____ - _____ Birth Date: _____ / _____ / _____
M D Yr

Emergency Contact: _____ (_____) _____ - _____
Name Relationship Phone

Whom may we thank for referring you? _____

Medical History

Have you ever had any of the following? (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Nervous System Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve/Joints | <input type="checkbox"/> Allergies to Medications | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Jaundice or Liver Disease | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Recent Weight Loss |

Have you ever taken Phen Phen or Redux? _____

(Women) Do you suspect that you are pregnant? _____ Are you Nursing? _____

Do you have any drug allergies or have you ever had an adverse reaction to medication? If so, please explain: _____

Are you currently taking any medication? _____ If so, please list: _____

Are you currently under the care of a physician? _____ If so, for what condition(s): _____

If the patient is a child, what is his or her weight? _____

Is there anything else that we should know about the patient's medical history? _____

Dental History

Have you had any sinus trouble associated with any previous dental work? _____
Yes or No

Are you wearing a removable dental appliance? _____
Yes or No

When were you last seen by a dentist? _____ For what? _____

When was your last professional teeth cleaning? _____

Have you ever been diagnosed with a periodontal disease? _____ If so, what? _____
Yes or No

Financial Responsibility

Please Read Carefully

I hereby authorize payment directly to Dr. Mike Pulido, otherwise payable to me. A photocopy of my signature may serve as the original. I authorize and consent to all dental work performed by attending provider for all family members. Payment is due when services are rendered. All patient co-payments and deductibles for insurance purposes must be paid at time of visit. This office will assist the patient, if possible, by completing and filing the necessary forms, but the responsible party, by signature below, accepts full responsibility for outstanding balances after thirty (30) days. The responsible party, by signing below, understands and agrees to pay a 1.5% monthly finance charge with a minimum \$5.00 balance that has been outstanding in excess of sixty (60) days. All missed or broken appointments without twenty-four (24) hour notice will be subject to a \$50.00 charge per missed visit. If this account becomes delinquent or is placed with an attorney, a collection agency, or any other instrument for collections, the undersigned responsible party agrees to pay all attorney or collection fees associated with the collection of this bad debt.

Signature of Responsible Party _____ Date: _____ / _____ / _____
Month Day Year

For subsequent visits only: I have read and reviewed my answers to the medical history and have noted all changes:

1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____
Initials Date Initials Date Initials Date Initials Date Initials Date Initials Date