Maddox DENTISTRY
EXCELLENCE IN ORAL HEALTHCARE

1100 RICKARD RD. SPRINGFIELD, ILLINOIS 217.546.4738
www.maddoxdentistry.com
info@maddoxdentistry.com

ADULT REGISTRATION & HEALTH HISTORY FORM

Name_____ Date of birth _____

Phone _____ Cell Phone _____E-mail _____

Address_____City_____State_____Zip_____

Place of Employment_____ Work Phone _____ Soc. Sec. #_____

Person Responsible for Payment: _____

Dental Insurance _____ Name of Insured _____

Birth date of Insured _____ Soc. Sec. #_____

Address if different from above_____

Spouse Name_____ Employer_____ Work Phone_____

Person to contact in case of emergency_____ Phone_____

Referred by? _____

MEDICAL HISTORY

Are you in good health? Yes ☐ No ☐ If no, please explain: _____

Do you have an existing illness? Yes ☐ No ☐ If yes, please explain: _____

Do you bleed excessively when cut? Yes ☐ No ☐ Do you smoke? Yes ☐ No ☐ If yes, how much? _____

Are you taking any medications, pills, or drugs? Yes ☐ No ☐ If yes, please list: _____

Do you have or have you had any of the following?: (If so, please describe under Remarks on the next page).

☐ Arthritis
☐ Artificial Implants
☐ Asthma
☐ Cancer History
☐ Diabetes
☐ Epilepsy
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Stroke
☐ Tuberculosis
☐ Tumor History
☐ Allergy to: Penicillin ☐
Other Antibiotics ☐
Latex ☐
Other ☐
☐ Are you pregnant?
☐ Acquired Immune Deficiency Syndrome
☐ Venereal Disease
☐ Mitral Valve Prolapse

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Have you ever had any complications following dental treatment? Yes ☐ No ☐

If yes, please explain: _____

Have you been admitted to a hospital or required emergency care during the past two years? Yes ☐ No ☐

If yes, please explain: _____

Are you under the care of a physician? Yes ☐ No ☐

If yes, please explain: _____

Name of personal physician: _____

Phone: _____

Do you have any health problems that need further clarification? Yes ☐ No ☐

If yes, please explain: _____

Have you ever been dissatisfied with the services of a dental office? Yes ☐ No ☐

If yes, please explain: _____

REMARKS:

_____

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I understand that I am financially responsible for all charges rendered, whether or not paid by an insurance carrier, and balances over 60 days will be charged a monthly service fee of 1.5% (18% APR) for each month the balance is carried. In the case of default, I promise to pay any legal interest on balances due together with any collection costs and reasonable attorney's fees incurred to affect collection of this account. I understand credit bureau reports may be obtained. I have reviewed and/or received a copy of this office's Notice of Privacy Practices. I agree to have any photos taken of my face or mouth to be used for educational and training purposes. This is to serve as my "signature on record."

I CONSENT TO WHATEVER DENTAL PROCEDURES AND ANESTHETICS ARE NECESSARY FOR THE TREATMENT RENDERED.

SIGNATURE _____ DATE _____