Patient Registration (Please complete all blanks)
Date_____

Patient Name_____Social Security/ID# _____
Address_____city_____st_____zip_____
E-mail_____ Would you like email/text reminders Yes : O No: O
Telephone: Home_____Cell_____Work_____
Birthdate: M_____D_____Y_____ Age_____ Male: O Female: O
Occupation_____Business Name_____

Parent/Spouse Name_____
Social Security/ID# _____ Birthdate: M_____D_____Y_____
Telephone: Home_____Cell_____Work_____
Occupation_____Business Name_____

Person responsible for account_____ Relation_____
Emergency Contact (other than parent/spouse)_____Phone_____
Previous Dentist_____

Referred By: **O** - patient referral **O** -1800dentist **O** - phonebook **O** - valpak **O** - walkin **O** – website **O** – google **O** - other

Please select type of care desired so that we may better serve your needs:

Temporary Relief - **O** Emergency Care Only - **O** Total Dental Care – **O**

Authorization for Treatment

I_____hereby grant authority to Dr. Bradford B. Fisher D.D.S., located at 207 7th Avenue South Nampa, Idaho 83651, and/or to the dentist(s) in charge of my care, permission to administer any treatment; anesthetics; or to perform such operations as may be deemed necessary in the diagnosis and treatment of my case. I further acknowledge my right to be informed of the risks and possible consequences of the treatment proposed and do authorize the above named doctor(s) to procees.

Signature _____**Date**_____
(Patient or nearest relative/guardian if minor or disabled)

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. ANY EXCEPTION MUST BE CLEARED *PRIOR* TO DENTAL CARE. IF YOU HAVE DENTAL INSURANCE COVERAGE, PLEASE COMPLETE BELOW:

Name of Policy Holder_____Policy Holder SS/ID#_____
Insurance Company_____Group#_____

Secondary Insurance (if any)
Name of Policy Holder_____Policy Holder SS/ID#_____
Insurance Company_____Group#_____

I hereby authorize release of any informantion relating to dental claims through this office to my insurance carrier. I understand that I am responsible for ALL cost for my dental care, regardless of insurance coverage. I hereby authorize payment of my insurance benefits, otherwise payable to me to *Dr. Bradford B. Fisher, D.D.S.*

Signature _____ **Date**_____

Medical History

This medical information is important to help us help you. Please take a few minutes to complete the information below. Check **ANY** of the following conditions that you have experienced in the past or are currently experiencing:

O Heart Failure	O Emphysema	O Cortisone Medication
O Heart Disease	O Cough	O Glaucoma
O Angina	O Tuberculosis	O Jaw Pain
O High Blood Pressure	O Asthma	O HIV/AIDS
O Low Blood Pressure	O Lung Disease	O Hepatitis A___B___C___
O Heart Murmur	O Hay Fever	O Liver Disease
O Rheumatic Fever	O Sinus Problems	O Yellow Jaundice
O Congenital Heart Valve	O Allergies	O Blood Transfusion
O Scarlet Fever	O Diabetes	O Hemophilia
O Artificial Heart Valve	O Thyroid Disease	O Veneral Disease
O Heart Surgery (Year_____)	O X-ray Colbalt Therapy	O Cold Sores
O Cardiac Pacemaker	O Chemotherapy	O Herpes
O Artificial Joint	O Osteoporosis/Bone Density	O Eplilepsy/Seizures
O Anemia	O Use of Bisphosphonates	O Fainting /Dizziness
O Stroke	ie-Aredia, Zometa(IV)	O Nervousness
O Alcoholism	Boniva, Fosamax (pills)	O Psychiatric Care
O Use Tobacco	O Arthritis	O Bruise Easily
O Drug Addiction	O Rheumatism	O Ulcers

Medical Doctors_____

Are you having pain or discomfort? O Yes O No

Have you been hospitalized during the past two (2) years? O Yes O No

Are you currently taking or have taken any medication in the past (2) years? O Yes O No

Please list **ALL** medications _____

Are you **allergic** to: Medication (Penicillin, Aspirin, Codeine, Novocaine) Latex, Jewelry O Yes O No

Other_____

Have you ever had excessive bleeding which required special care? O Yes O No

Do you have shortness of breath walking up stairs or sleeping? O Yes O No

Do you tire easily? O Yes O No

Do you ankles swell during the day? O Yes O No

Is it necessary to use more than two pillows to sleep? O Yes O No

Have you lost or gained more than ten pounds during the past year? O Yes O No

Are you on a special diet? O Yes O No

Has your medical doctor diagnosed cancer or a tumor? O Yes O No

Women: Are you pregnant? O Yes O No **How far along?** _____

Are there any other problems, disease, or conditions that we should know about? O Yes O No

_____

To the best of my knowledge, all the preceding answers are true and correct. If my health should change, or if my medications should change, I will inform the dentist at my next appointment without fail.

Signature _____ **Date**_____

Thank you for your help in completing this form.