PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

JOHN A GUERRIERI DDS LTD
421 W IRVING PARK ROAD
ITASCA, IL 60143
84 7 250·5394
847 250-5393 FAX

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient number _____

Patient address _____

Patient phone number _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

PATIENT INFORMATION

Note: the information on this form is necessary for our records. It is considered strictly confidential. Please complete all parts.

NAME _____ Age _____
Last *First* *Middle*

ADDRESS _____
Street *City* *State* *Zip Code*

PHONE _____ _____ OCCUPATION _____
Residence *Business*

PHYSICIAN _____ PHONE _____

WHO WILL PAY THIS ACCOUNT? _____

DO YOU HAVE DENTAL INSURANCE? _____ INSUROR _____

WHO RECOMMENDED YOU TO THIS OFFICE? _____

★★★★★★★★★★

Are you now under the care of a physician?	Yes ☐	No ☐
Are you now taking any drug or medicine?	Yes ☐	No ☐
Have you been hospitalized in the last two years?	Yes ☐	No ☐
Are you allergic or sensitive to ANYTHING (Drugs, dental anesthetics, penicillin, etc.)?	Yes ☐	No ☐
Have you ever taken cortisone or steroids?	Yes ☐	No ☐
Do you get out of breath easily?	Yes ☐	No ☐
Do your ankles often swell?	Yes ☐	No ☐
Do you smoke?	Yes ☐	No ☐
Females only: Are you pregnant?	Yes ☐	No ☐

Do you have or have you had? Circle.

Heart trouble	Bleeding problem	Stomach, intestinal trouble
Rheumatic fever	Arthritis	Stroke
High blood pressure	Tuberculosis	Circulatory problems
Diabetes	Venereal disease	Blood disease
Liver disease	Cancer	Eye, ear, nose, throat trouble
Epilepsy	Thyroid disease	Hepatitis
Asthma	Fainting spells	Sinus trouble
Strep Throat	X-Ray Therapy	Kidney Disease
Pneumonia	A.I.D.S.	Severe Headaches

Indicate any disease, condition, or problem not listed above that you think I should know about

_____

_____

REMARKS:

PERMIT FOR TREATMENT

This is to certify that I, undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's) Signature _____ Date _____