LUXE DENTAL SPA
257 Monmouth Road, Oakhurst, NJ 07755
(732) 531-0777

PATIENT REGISTRATION AND MEDICAL HISTORY

(Please Print)

Patient: _____ Date: _____
(Last name) (First Name) (Middle Initial) (Preferred name)

Home Phone: _____ Mobile: _____ E-mail: _____ Preferred contact Method: _____

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

Sex: ☐ Male ☐ Female Age: _____ Birth date: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse Name: _____ Spouse's Birth Date: _____

Spouse Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Patient's Social Security Number: _____ Spouse's Social Security Number: _____

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

Dental Insurance Company: _____ Group #: _____ Name of Policy Holder: _____

In case of emergency, who should be notified? _____ Phone Number: _____

Whom can we thank for referring you? _____

MEDICAL HISTORY

Physicians Name: _____ Date of last physical: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Have you ever had any of the following? (check boxes that apply)

☐Heart Problems
☐High Blood Pressure
☐Low Blood Pressure
☐Circulatory Problems
☐Nervous Problems
☐Radiation Treatment
☐Artificial Heart Valves or Joints
☐Recent Weight Loss
☐Back Problems
☐Diabetes
☐Respiratory Disease
☐Asthma
☐Epilepsy
☐Headaches
☐Hepatitis, Jaundice or Liver Disease
☐Cancer
☐Psychiatric Care
☐Chronic Diarrhea
☐Allergies to Anesthetics
☐Allergies to Medicine or Drugs
☐General Allergies
☐Blood Disease, Hemophelia
☐Arthritis
☐CardiacPacemaker
☐Special Diet
☐Swollen Neck/Glands
☐Rheumatic Fever
☐Sinus Problems
☐HIV/AIDs or Other ImmunosuppresiveDisorder
☐Stroke
☐Ulcer
☐Venereal Disease
☐Chemical Dependency
☐Thyroid Disease
☐Tuberculosis

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

Do you have to premedicate with antibiotics due to heart valve or joint replacement? _____ If so, with what? _____

Have you had any canker sores or cold sores on your tongue, gums or body? _____

Have you ever had excessive bleeding requiring special treatment? _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what _____

Are you under the care of a physician? ☐Yes ☐No For what conditions? _____

(Woman) Do you suspect that you are pregnant? ☐Yes ☐No Are you nursing? _____

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

APPOINTMENTS: A $75.00 charge may be applied for failed or cancelled appointments without 24 hours prior notification. Once an appointment is made, please remember this time has been reserved for you.

RETURNED CHECKS AND COLLECTION FEES: There will be a $35.00 charge for all returned checks, including non-sufficient funds and stop payment. All collection fees, including court costs and attorney fees, will be charged to your account and will be your responsibility.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the person responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for payment of fees. We can prepare necessary forms or reports to help the person responsible to obtain benefits from insurance companies, upon receipt of full (or partial) payment of bill.

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 will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____