Dentofacial Associates, P.A. • 435 W. Landis Ave
Vineland, NJ • (856)691-3220

PATIENT REGISTRATION AND MEDICAL HISTORY

Today's Date _____ Home Phone ( ) _____ Cell Phone ( ) _____
First Name _____ Last Name _____ Middle Initial____
Sex ☐M ☐F Birth Date (MM/DD/YYYY) _____ ☐Single ☐Married ☐Widowed ☐Divorced
Address _____ Social Security # _____
City _____ State _____ Zip _____
Employer Name _____ Phone _____ Occupation _____
In case of emergency. who should be notified? **Name:** _____ **Phone:** _____

PRIMARY INSURANCE

Person Responsible for Account _____ Relation to Patient _____
Birth Date _____ Social Security # _____
Address (If different from Patient) _____ Phone ( ) _____
City _____ State _____ Zip Code _____
Person Responsible employed by _____ Occupation _____
Business Address _____ Business Phone ( ) _____ Ext____
Insurance Company _____ Subscriber ID # _____ Group # _____

SECONDARY INSURANCE

Subscriber's Name _____ Relation to Patient _____
Birth Date _____ Social Security # _____
Address (If different from Patient) _____ Phone ( ) _____
City _____ State _____ Zip Code _____
Person Responsible employed by _____ Occupation _____
Business Address _____ Business Phone ( ) _____ Ext____
Insurance Company _____ Subscriber ID # _____ Group # _____

****ASSIGNMENT AND RELEASE (Insured Only)**
I, the undersigned, have insurance with _____ and assign direct to Dentofacial Associates, P.A. all benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
Date _____ Signature _____

****FINANCIAL AGREEMENT (Insured and Self Pay)**
I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor child. I accept full financial responsibility for all charges not covered by insurance.
Date _____ Signature _____

****PHOTO WILL BE TAKEN *****
I have been advised that a photo will be taken for identification purposes on my initial visit.
Initials _____

☞Turn Over →→→

Physician's Name _____ Phone # _____
Cardiologist's Name _____ Phone # _____

✓**Check boxes that apply:**

☐Abnormal bleeding
☐Allergies_____
☐Anemia
☐Arthritis
☐Artificial Replacement
☐Back Problems
☐Blood Disease
☐Cancer
☐Chemical Dependency
☐Chronic Disease
☐Cholesterol
☐Circulatory Problems
☐Diabetes
☐Epilepsy
☐Heart Problems
☐Hemophilia
☐Hepatitis
☐High Blood Pressure
☐HIV/ AIDS
☐Headaches
☐Low Blood pressure
☐Liver Disease
☐Nervous Problems
☐Pace maker
☐Psychiatric Care
☐Radiation Treatment
☐Recent Weight Loss
☐Venereal disease
☐Rheumatic Fever
☐Sinus Problems
☐Smoker
☐Stroke
☐Thyroid
☐Ulcer
☐Respiratory Disease

Are you taking: Coumadin ☐Yes ☐No / Aspirin ☐Yes ☐No / Plavix ☐Yes ☐No?
Are you allergic to any medications? ☐Yes ☐No Please List: _____
Are you taking any medications? ☐Yes ☐No Please List: _____
Are you under the care of a physician? ☐Yes ☐No If so, for what condition(s)? _____
Do you suspect you are pregnant at this time? ☐Yes ☐No Are you nursing? ☐Yes ☐No

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(s) for benefits for which I an entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions I may have made in the completion of this form.
Date_____ **Signature** _____

----------**MINOR/CHILD CONSENT**----------

I, being the parent/guardian of _____, do herby request and authorize the dental staff
Name of minor
to perform necessary dental services for my child, including but not limited to, x-rays and administration of anesthetics which are deemed advised by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

When I an unable to bring my child to their appointment, I authorize the following people:
Name: _____ Relation: _____
Name: _____ Relation: _____
I understand the people above **must** bring proper **identification** with them at the time of the appointment.
Date_____ **Signature** _____

Dentofacial Associates, P.A. strives to provide quality customer service to our patients. As a courtesy, we supply our patients with as much help as possible. We are not responsible for being up to date with patient's insurance coverage, exclusions, limitations, or any outstanding balances not paid by your insurance. Ultimately, it is the member's responsibility for understanding his/ her dental coverage, plan exclusions, limitations, as well as tracking benefits used to date.
Dentofacial Associates, P.A. reserves the right to charge a $25 fee after 3 consecutive missed appointments
Date _____ **Signature** _____