

Murthy Dental Clinic REGISTRATION FORM

Today's date:			
PATIENT INFORMATION			
Name <i>(Last, First, M.I.):</i>		Age:	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:		Home phone no.: ()	SSN:
City:	State:	ZIP:	
Present Position:	Employer:	How long:	Business Phone no.: ()
Purpose of this appointment:			
Other family members seen here:			
Name of the person to thank for referral:			
SPOUSAL/PARENTAL INFORMATION			
<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Husband <input type="checkbox"/> Wife		<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Husband <input type="checkbox"/> Wife	
Name <i>(Last, First, M.I.):</i>		Name <i>(Last, First, M.I.):</i>	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Employer:		Employer:	
Employer Address:		Employer Address:	
City:	State:	ZIP:	City: State: ZIP:
Employer Phone no.:		Employer Phone no.:	
Home Address:		Home Address:	
City:	State:	ZIP:	City: State: ZIP:
Home phone no.:		Home phone no.:	
INSURANCE INFORMATION			
Person responsible for bill:	DOB:	Address (if different):	Home phone no.: ()
Present Position:	Employer:	Employer address:	Employer phone no.: ()
Is this patient covered by insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Please indicate primary insurance:
Subscriber's name:	Subscriber's SSN:	DOB:	Group no.: Policy no.:
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other
Is policy connected with your union?	Name of Union:	Local no.:	Group no.:
<input type="checkbox"/> Yes <input type="checkbox"/> No			
IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()

HEALTH HISTORY QUESTIONNAIRE

Today's date:

Name *(Last, First, M.I.):*

Age:

DOB:

Marital status: Single Married Separated Divorced Widowed

Sex: M F

Previous or referring doctor:

Date of last health exam:

Date of last health exam:

For what reason(s)?

Have you been hospitalized in last 5 years?

Yes No

SURGERIES OR OTHER HOSPITALIZATIONS

Year	Reason

Do you have or have you ever had:

• Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Abnormal Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Abnormal Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	• Abnormal Bleeding from cut	<input type="checkbox"/> Yes <input type="checkbox"/> No

Women: Are you pregnant?

Yes No

Are you allergic to:

- Penicillin Yes No
- Local Anesthetic Yes No

Are you allergic to any drugs?

Yes No

ALLERGIES TO MEDICATIONS OR DRUGS

Name the Drug	Reaction You Had

Are you taking any medication?

Yes No

LIST MEDICATION YOU ARE TAKING

Name the Drug	Reason for medication

Are there any physical conditions? If any, list them

Yes No

Name of your physician:	Address:	Phone no.:

May we request your health record, if necessary

Yes No

To whom should we address request:

This information was given by:

Shantha Murthy, DDS

1605 W. Candletree Dr. Unit 114
Peoria, IL 61614
Ph. (309) 686-1100

138 E. Fort St.
Farmington, IL 61531
Ph. (309) 245-2922

OUR FINANCIAL AND CANCELLATION/RESCHEDULING POLICY

Thank you for choosing our office to provide you with superior dental care. We believe in making this a lifetime commitment.

Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial and cancellation/rescheduling policy, which we require that you read, agree to, and sign before we begin treatment.

- All charges you incur are your responsibility, regardless of your insurance coverage.
- We ask that you pay your deductible and co-payment at the time of service.
- Payment Options
 1. Cash or Check
 2. MasterCard or Visa
 3. Care Credit – A payment plan that allows you to start treatment today and spread payments over time.
- As a courtesy, we will work with your insurance company to get you the maximum dental benefit, but we will not enter into a dispute with your insurance company over any claim.
- We will start charging interest of 1 ½ % per month (18 % per annum) on accounts over 60 days.
- **Short Notice Cancellation/Rescheduling (Except Medical Emergencies)**
- Any **Weekday Rescheduling/Cancellation** short of **72 hours** notice will be charged \$45.00 and up.
- Any **Saturday Rescheduling/Cancellation** short of **one weeks** notice will be charged \$65.00 and up

We welcome any questions you may have concerning your dental care and/or our financial/cancellation policy.

I have read, understand and agree to the above terms and conditions.

Patient Name

Patient/Guardian Signature

Date