

**Manhattan Dental Associates  
Patient Registration**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Date \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
If married, spouse's name \_\_\_\_\_  
Home address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Email address \_\_\_\_\_  
Employer \_\_\_\_\_ Business address \_\_\_\_\_  
Insurance company \_\_\_\_\_ Name of Union \_\_\_\_\_  
Name and Social Security # of Insured person \_\_\_\_\_  
\_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_  
In case of emergency who should we contact? Name \_\_\_\_\_

**All delinquent balances are subject to 1.5% monthly finance charge.** Any collection expenses incurred are the responsibility of the patient. As a service to our patients, we will accept your Dental Insurance as full or partial payment for services rendered in our office. We ask that any difference between our fees and the amount paid by the insurance company be paid by you the patient.  
**We reserve the right to charge for appointments cancelled or broken without 24 hours notice. Returned checks will be subject to a \$25.00 fee.**

**Medical History**

Have you ever had? **Answer yes or no.**

High blood pressure _____	Thyroid disease _____
Liver disease _____	Venereal disease _____
Rheumatic fever _____	Asthma _____
Hepatitis _____	Epilepsy _____
Diabetes _____	AIDS?HIV Positive _____
Heart Disease _____	Heart murmur _____
Heart Attack/Stroke _____	Cancer/Tumor _____
Orthopedic Pins _____	Artificial Heart Valve _____
Kidney Disease _____	Other _____

Have you ever had a bad reaction to *penicillin, codeine, Novocain or any other medication*? \_\_\_\_\_

Are you allergic to latex? \_\_\_\_\_ Any other allergies? \_\_\_\_\_

Have you ever had prolonged bleeding from a cut or following extraction of a tooth? \_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_\_ For what reason? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Do you smoke? \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_ Date of last physical? \_\_\_\_\_

Are you presently under physician's care? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ What did you have done at that visit?

\_\_\_\_\_ Your reason for today's visit? \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_