ROBERT L. PORTER
DENTISTRY

PATIENT REGISTRATION AND MEDICAL HISTORY
(PLEASE PRINT)

Patient Name ______________________________
Address ______________________ City ______________ State ________ Zip __________
Home Phone ______________ Work Phone ______________ Cell Phone ______________
Date of Birth ______________ S.S. # ______________ Sex: M F Marital Status: S M D W
Employer ______________________ Business Address ______________________
Spouse's Name ______________ Date of Birth ______________ S.S. # ______________
Spouse's Employer ______________ Business Address ______________________
Names of other family members seen in our office ______________________
Who should be notified in case of an emergency? ______________________
Whom should we thank for referring you? ______________________

Medical History

Name and phone number of your physician ______________________
Have you ever had any of the following? (Please circle those that apply)

HEART DISEASE
HEART MURMUR
ANEMIA
ARTHRITIS
DIABETES
ARTIFICIAL VALVE / JOINT
BACK PROBLEMS

HEPATITIS, JAUNDICE
RHEUMATIC FEVER
HIGH BLOOD PRESSURE
STROKE
ULCERS
VENEREAL DISEASE
RADIATION THERAPY

LIVER DISEASE
EPILEPSY
ASTHMA
CANCER
AIDS / HIV
HEMOPHILIA
OTHER

Are you currently being treated for any health problems? ______________________
What medications are you currently taking? ______________________
Are you allergic to Penicillin ______ Codeine ______ Erythromycin ______ Aspirin ______ Local Anesthetic ______
Any other medical allergies or adverse reactions? ______________________
Female patients: If pregnant, how long ________ Any other conditions? ______________________
Purpose of this visit ______________________
What would you like to change about your smile? ______________________
How long has it been since you had your teeth cleaned? ______________________

Consent: The undersigned hereby authorizes Dr. Porter to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Porter to make a thorough diagnosis of the patient's dental needs. I further authorize Dr. Porter to employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.
Patient's Signature ______________________ Date ______________

We require a 24 hr. notice of cancellation when you cannot keep your appointment. This allows us to give the appointment time to another patient. Failure to show, or cancellation without 24 hr. notice will incur a $35.00 charge.

Patient's Signature ______________________ Date ______________

OUR POLICY: We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager in writing.

INSURANCE: I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize insurance providers to release any information required to process insurance claims. I authorize assignment of my insurance rights and benefits to my dental service provider. I authorize the staff to bill my insurance carriers for services rendered. I will provide accurate and current information necessary to facilitate submitting the insurance claim in a timely fashion. I accept full financial responsibility for dental services rendered not paid by insurance.

PAYMENT: Payment is due on the day dental services are rendered. Crowns, bridges and appliances will not be delivered until the account balance is paid in full. All accounts thirty days past due will accrue an interest charge of 1.5% interest per month.

PAYMENT ARRANGEMENTS: All payment arrangement must be in writing.

ENTIRE AGREEMENT: This Agreement embodies the entire agreement among the parties and there have been and are no agreements, representations or warranties, oral or written among the parties other than those set forth or provided for in this Agreement. This Agreement may not be modified or changed, in whole or in part, except by a supplemental agreement signed by each of the parties. This Agreement shall be governed by and construed in accordance with the laws of the State of Texas and exclusive venue in Dallas County, Texas. In any action taken to enforce or interpret this agreement, the prevailing party will be entitled to recover all costs and expenses, including court costs and reasonable attorneys' fees.

PAYMENT ARRANGEMENTS:

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Patient Signature ____________________________________ Date __________________