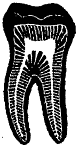

Dr. Robert L. Sherman • Dr. Stuart O. Miller

Patient Registration Data Form

Please provide this office with a picture ID for copying for your chart.

Initial Date: ____________
Review Date: ____________
Chart #: ____________

Have you or anyone in your immediate family been to our office? ☐ NO ☐ YES If yes, who? ____________

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms

☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Partner

Patient Name ____________ Age ______ Birth Date ____________ ☐ Male ☐ Female

Address ____________ City ____________ State ______ Zip ______

Phones: Home ______ Cell ______ Work ______ Student? ☐ Yes ☐ No ☐ Full-*time* ☐ Part-time

Social Security Number ____________ Driver's License Number ____________ State ______

Employer's Name ____________ Phone ____________

Address ____________ City ____________ State ______ Zip ______

Spouse's Name ____________

Referred By ____________

General Dentist ____________

Emergency Contact Name & Phone Numbers ____________

Insurance Information - *Please present insurance cards for copying for your chart.*

Primary Dental Insurance:

Employer's Name ____________

Insurance Company's Name ____________ Policy Number/SS# ____________

Phone Numbers ____________ Acct./Group Number ____________

Policy Holder's Name ____________ Policy Holder's Birth Date ____________

If Military, what rank is sponsor? ____________ Patient's relationship to Policy Holder ____________

Secondary Dental Insurance:

Employer's Name ____________

Insurance Company's Name ____________ Policy Number/SS# ____________

Phone Numbers ____________ Acct./Group Number ____________

Policy Holder's Name ____________ Policy Holder's Birth Date ____________

If Military, what rank is sponsor? ____________ Patient's relationship to Policy Holder ____________

Benefit Assignment/Agreement to Pay:

I hereby authorize my insurance benefits to be paid directly to Dr. Robert L. Sherman / Dr. Stuart O. Miller. I understand that I am responsible to Dr. Dr. Robert L. Sherman / Dr. Stuart O. Miller for payments made directly to me and for any services or charges not covered by my insurance carrier.

Signature of Claimant or Guardian ____________ Date ____________

(If patient is under the age of 18) - Account Information

Responsible Party (RP) Information:

(RP) Name ____________ Age ______ Birth Date ____________ ☐ Male ☐ Female

Address ____________ City ____________ State ______ Zip ______

Phones: Home ______ Cell ______ Work ______ Other ______

Social Security Number ____________ Driver's License Number ____________ State ______

(Continued on Reverse Side)

Health History: *Please Check Yes or No*

Yes	No	
____	____	AIDS
____	____	Anemia/Blood Disease
____	____	Arthritis
____	____	Asthma/Hay Fever
____	____	High Blood Pressure
____	____	Low Blood Pressure
____	____	Cancer/Tx/x-ray - Date: ________________
____	____	Diabetes
____	____	Epilepsy/Seizures
____	____	Glaucoma
____	____	Heart Murmur
____	____	Heart Trouble - Date: ________________
____	____	Hepatitis
____	____	Herpes Virus
____	____	HIV Positive
____	____	Joint Replacement - Date: ________________
____	____	Liver Disease
____	____	Lung Disease
____	____	Migraine Headaches
____	____	MVP - Mitral Valve Prolapse
____	____	Sleep Apnea
____	____	Stroke - Date: ________________
____	____	Pregnant? - Due Date: ________________
____	____	Are You Taking Birth Control?
____	____	Pre-Med for Dental Tx?
____	____	Gastric Bypass - Date: ________________
____	____	Other: ______________________________

Are you Allergic To: *Please Check Yes or No*

Yes	No	
____	____	Aspirin
____	____	Codeine
____	____	Local Anesthesia
____	____	Penicillin
____	____	Sedative
____	____	Sulfa
____	____	Latex
____	____	Motrin
____	____	Clindamycin
____	____	Other: ______________________________
____	____	Other: ______________________________

List Medications you are taking and what you are taking them for: *(including nonprescription drugs)*

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

Financial Policy: *Please Read and Initial the Following:*

_______ 1. This office requires verbal confirmation of our working appointments. Without verbal confirmation of your appointment it will be cancelled. (Verbal confirmation is allowed to be left on our answer machine for your convenience.)

_______ 2. Payment is due on the day of service. For your convenience our office accepts cash, checks, Visa, MasterCard, & Care Credit.

_______ 3. It is your responsibility to give us your correct insurance information so that, as a courtesy for you, we can file the claim for you.

_______ 4. Professional services are rendered and charged to You and not to the insurance company. Some insurance companies provide no coverage, very few will pay the entire charge, and some do not cover re-treatment of a previous root canal treatment.

I, the undersigned, consent to the performing of the Endodontic Procedure that may be decided upon to be necessary or advisable in the opinion of the doctors. I also understand that I am to return to the GENERAL DENTIST FOR FINAL RESTORATION of the treated teeth, or placement of crown.

I, the undersigned, also consent to the filing of the provided dental insurance and direct payment to the provider of service. A fee may be charged for appointment cancelled with less than 24 hours notice.

A fee of 1.5% will be charged monthly for unpaid balances. The Returned Check fee is $32.00.

Signature of Patient/Parent or Guardian of minor:______________________________ Date______________