Ranu Mishra, D.D.S., M.S.
PROSTHODONTICS & IMPLANT DENTISTRY

DATE

PATIENT REGISTRATION

PATIENT INFORMATION

First Name | Middle | Last | Sex ❑ Male ❑ Female

Address | City | State | Zip | Email:

Date of Birth / / | Social Security # - - | Home Phone # ( ) | Work Phone # ( ) | Cell Phone # ( )

Employer Name | Address | City | State | Zip | Position

❑ Single ❑ Married ❑ Divorced ❑ Widowed | Spouse First Name | Last Name | If full-time college student, Name of School | City, State

PRIMARY INSURANCE INFORMATION

IF DIFFERENT FROM ABOVE

First Name of Person Carrying Insurance | Middle | Last | Sex ❑ Male ❑ Female

Address | City | State | Zip

Date of Birth / / | Relationship to Patient | Home Phone # ( ) | Work Phone # ( ) | Cell Phone # ( )

Employer Name | Address | City | State | Zip | Position

Insurance Company Name | Address | City | State | Zip

Social Security # | Group #

SECONDARY INSURANCE INFORMATION (if applicable)

IF DIFFERENT FROM ABOVE

First Name of Person Carrying Insurance | Middle | Last | Sex ❑ Male ❑ Female

Address | City | State | Zip

Date of Birth / / | Relationship to Patient | Home Phone # ( ) | Work Phone # ( ) | Cell Phone # ( )

Employer Name | Address | City | State | Zip | Position

Insurance Company Name | Address | City | State | Zip

Social Security # | Group #

PERSON TO RECEIVE MONTHLY BILLING STATEMENT (and cover what insurance does not)

First Name | Middle | Last | Relationship to Patient

WHOM MAY WE THANK FOR REFERRING YOU?

Name

IN CASE OF EMERGENCY NOTIFY

Name | Phone | Relationship to Patient

Relative or friend not living with you:

Name ________________________ Address ________________________ Phone ________________

I certify that the above information is accurate and complete. I hereby authorize my insurance company(s) to pay directly to Ranu Mishra, D.D.S, M.S. benefits due me out of indemnity under the terms of my policy issued by my company(s). Payment is authorized upon receipt of his itemized statement for services rendered to me. This policy was in full force and effect at the time that these services were rendered.

I understand and agree that, (regardless of my personal insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. A 1-1/2% finance charge will be assessed on any balance over 90 days old. I have read all the information on this sheet and I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature ____ Date ________________

Ranu Mishra, D.D.S., M.S.
PROSTHODONTICS & IMPLANT DENTISTRY

PATIENT REGISTRATION

DATE

PATIENT INFORMATION

First Name	Middle	Last	Sex ❏ Male ❏ Female
Address	City	State / Zip	Email:
Date of Birth / /	Social Security # - -	Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )

Employer Name	Address	City	State	Zip	Position

❏ Single ❏ Married ❏ Divorced ❏ Widowed	Spouse First Name	Last Name	

If full-time college student, Name of School	City	State

RESPONSIBLE PARTY (who pays the bills - if different from above) INFORMATION

First Name	Middle	Last	Sex ❏ Male ❏ Female
Address	City	State	Zip
Date of Birth / /	Social Security # - -	Home Phone # ( )	Work Phone # ( )

Employer Name	Address	City	State	Zip	Position

How long at present address ❏ Rent ❏ Own ❏ Parents	Relationship to patient
How long with present employer	If less than one year, Previous Employer

WHOM MAY WE THANK FOR REFERRING YOU?

Name

IN CASE OF EMERGENCY NOTIFY

Name	Phone	Relationship to Patient

Relative or friend not living with you:

Name ____ Address ____ Phone _________________________

I certify that the above information is accurate and complete.

A 1-1/2% finance charge will be assessed on any balance over 90 days old. I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature ____ Date ___________________________________

Ranu Mishra, D.D.S., M.S.

Confidential Health History Form **Today's Date**______________

Patient Name: First____________________________**MI**______**Last**____________________________**Date of Birth**__________________

1. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. Yes / No Is your general health good?
   If NO, explain____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain____
3. Yes / No Have you gone to the hospital or had a serious illness in the last three years?
   If YES, explain____
4. Yes / No Are you being treated by a physician now?
   If YES, explain____
   Date of last medical exam?_______________ Reason for exam______________________________
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain____
   Date of last dental exam___________ Name of last treating dentist______________________________
6. Yes/ No Are you in pain now?
   If YES, explain____

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No	Heart disease	Yes / No	Cancer or Tumors	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Chemotherapy	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Radiation	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Cosmetic surgery	Yes / No	Hepatitis
Yes / No	Stomach problems or ulcers	Yes / No	Surgeries	Yes / No	Sexual transmitted disease
Yes / No	Heart defects	Yes / No	Hospitalization	Yes / No	Herpes
Yes / No	Heart murmurs	Yes / No	Diabetes	Yes / No	Canker or cold sores
Yes / No	Rheumatic fever	Yes / No	Family history of diabetes	Yes / No	Anemia
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Liver disease
Yes / No	Hardening of arteries	Yes / No	Emphysema or lung disease	Yes / No	Eye disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Transplants
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No	Aspirin	Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Vicodin
Yes / No	Darvon	Yes / No	Latex	Yes / No	Food	Yes / No	Percodan
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Valium	Yes / No	Erythromycin	Yes / No	Nitrous oxide
		Yes / No	Demerol	Yes / No	Tetracycline	Yes / No	Metal

Others____

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No)*

Yes / No	Antibiotics	Yes / No	Tobacco in any form	Yes / No	Recreational drugs
Yes / No	Supplements	Yes / No	Alcohol	Yes / No	Over-the-counter medicines
Yes / No	Aspirin	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Cortico - Steroids

Please list all medications you are currently taking______________________________

VI. Women Only *(Please circle Yes or No for each)*

Yes / No Are you or could you be pregnant? If YES, what month______________________________
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. All Patients *(Please circle Yes or No for each)*

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, explain______________________________
____

Yes / No Have you ever been pre-medicated for dental treatment?
If YES, why______________________________

Yes / No Have you ever taken Fen-Phen?
If YES, when______________________________

Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

**The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.
I authorize the dentist to contact my physician.**

Patient's Signature______________________________ **Date**______________________

Physician's Name ______________________________ **Phone Number**______________________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health &/or medication. Further, I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________ ____________ ______________________ ____________
Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**

Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	**Patient Signature**	**Changes to Health History**	**Dentist Initials**