PATIENT FINANCIAL RESPONSIBILITY FORM

Payment is due at the time of service, and for your convenience, we accept cash, check, discover, mastercard, visa, and carecredit if previously approved.

PATIENTS HAVING INSURANCE:

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. Lisa C Petrov all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature Date

REGISTRATION/PATIENT INFORMATION

Please Print

Patient's Name:_____
First Initial Last

Home Address:_____
Street

_____
City State Zip

Cell Phone:_____

Home Phone:_____ D.O.B.:_____ Age:_____

S.S.#:_____ Sex: M / F

Marital Status:_____ Spouse's Name:_____

If Patient is a Minor:_____
Name of person legally responsible

Employed by:_____

Occupation:_____ Business Phone:_____

Do you carry dental insurance? Y / N

Insurance carrier name:_____

Name of insured:_____ Relationship:_____

Insured S.S.#:_____ Insured D.O.B.:_____

Dentist who referred you here?_____

General Dentist:_____

Are you here as a result of an accident? Y / N

Date:_____ Nature:_____

Pharmacy Name:_____ Phone:_____

Please complete other side...

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical Exam_____

Please Indicate With A Check Mark ( )

1. Has there been any changes in your general health within the past year? Y / N
2. Are you under the care of a physician? Y / N
   If yes, nature of treatment:_____
3. Have you been hospitalized in the past 3 yrs? Y / N
   If yes, reason:_____
4. Are you pregnant? Y / N If yes, months:_____
5. Do you have any heart problems? Y / N
   If yes, please describe:_____
6. Do you have any of the following?
   Artificial or replacement heart valves_____ or pacemaker_____
   Artificial or replacement joints?_____ _____
7. Do you premedicate with an antibiotic prior to dental appointments? Y / N
8. Have you ever been treated for periodontal disease? Y / N
9. Are you allergic to any medications/anesthetics? Y / N
   If yes, please list_____

10. Do you have or have you ever had any of the following problems?

_____High B.P.	_____Slow Healing	_____Nervous Problems
_____Low B.P.	_____Excessive Bleeding	_____Psychiatric Care
_____Stroke	_____Hepatitis, _____ Type	_____Scarlet fever
_____Asthma	_____Anemia	_____Rheumatic fever
_____Diabetes	_____Arthritis	_____Thyroid
_____Circulatory	_____T. B.	_____Ulcer
_____Kidney Disease	_____Cancer	_____Aids
_____Seasonal Allergies	_____Malignancies	_____Sinus

11. Please list all current medications:_____

12. Do you have any disease, condition or problem not listed above? Y / N
    Additional information or remarks:_____

Patient Signature (or parent/guardian if minor)_____

Date_____