Dr. James L. Davis, D.M.D. • 1318 W. Candletree Drive • Peoria, Illinois 61614

PATIENT REGISTRATION

PATIENT

Date: _____ Cell: _____ E-mail Address: _____

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ Birthdate: _____ Social Security#: _____

If patient is a minor, give parent's or guardian's name: _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY

Name _____
Last First Middle Marital Status

Residence: _____
Street City State Zip

Mailing Address (if different from above): _____
Street City State Zip

How long at this address: _____ Home Phone: _____ Work Phone: _____

Previous Address (if less than 3 yrs): _____
Street City State Zip

Social Security#: _____ Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. of Years Employed: _____

Driver's License No.: _____

Spouse's Name: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. of Years Employed: _____

Social Security#: _____ Birthdate: _____ Work Phone: _____

INSURANCE

Insured's Name: _____ Insured's Soc. Sec. #: _____

Insurance Company: _____ Group No.: _____ Local No.: _____

Insurance Co. Address: _____
Street City State Zip

Do you have dual Coverage? Yes ❑ No ❑ If yes:

Insured's Name: _____ Insured's Soc. Sec.#: _____

Insurance Co.: _____ Group No.: _____ Local No.: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Employer: _____

EMERG

Name of nearest relative not living with you: _____

Complete Address: _____
Street City State Zip

Phone: _____

Signature (Parent's signature if minor): _____

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Physician's Name: _____ Phone No.: _____
4. Are you now taking any medication, drugs or pills? ..... YES NO

   If yes, please list: _____
5. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO

   If yes, please list: _____
6. Indicate which of the following you have had or have at present. Circle "YES" or "NO" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc)	YES	NO	Hepatitis B (serum)	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Arteriosclerosis	YES	NO	Cosmetic Surgery	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO
Stroke	YES	NO	Hepatitis A (infectious)	YES	NO	Developmentally Disabled	YES	NO

7. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
8. Do your ankles swell during the day? ..... YES NO
9. Do you use more than two pillows to sleep? ..... YES NO
10. Have you lost or gained more than 10 pounds in the last year? ..... YES NO
11. Do you ever wake up from sleep and feel short of breath? ..... YES NO
12. Are you on a special diet? ..... YES NO
13. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
14. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO

    If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ❑ Yes, what month?_____ ❑ No Are you nursing? ❑ Yes ❑ No Are you taking birth control pills? ❑ Yes ❑ No

CONSENT

1. I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
2. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I understand that where appropriate, credit bureau reports may be obtained.

Patient _____ Date _____

Parent or Responsible Party _____