Pratt DMD, PC
Robert Alan

PATIENT REGISTRATION FORM

Patient Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Birthday _____ Email _____
Soc. Sec. # _____ Sex: *(please check one)* ☐ Male ☐ Female
Employer _____ How Long _____ Work Phone _____

Relationship *(please check one)* Single ☐ Married ☐
Partner Name _____
Phone _____
Employer _____
Employer Phone _____

Emergency Contact *same as Relationship Contact* ☐
Spouse Name _____
Phone _____
Employer _____
Employer Phone _____

Insured Or Responsible Party Information

Name _____ Relationship _____
Address _____
City _____ State _____ Zip _____
Birthday _____ Phone _____
Soc. Sec. # _____ Employer _____

Insured Or Responsible Party Information

I Will Be Paying Today By: ☐ Cash ☐ Check ☐ Visa/Mastercard

Dental Insurance Co. _____
Address _____
City _____ State _____ Zip _____
Phone _____ Group # _____
Subscriber Name _____

Secondary Coverage

Dental Insurance Co. _____
Address _____
City _____ State _____ Zip _____
Phone _____ Group # _____
Subscriber Name _____

I understand and agree that regardless of insurance status, I am completely responsible for payment of my account for services rendered. I certify that the above information is true and correct. This signature on file is my authorization for the release of information necessary to process any of the insurance benefits. My signature authorizes that all insurance benefits are to be made payable directly to Dr. Robert Alan Pratt DMD, PC. This office reserves the right to verify the credit status of potential patients and/or parents of the patient prior to extending credit for treatment.

Signature _____ Date _____

Ph: (541) 276.4257 | Fax: (541) 276.3563
916 SW Court Avenue · Pendleton, Oregon 97801
www.PendletonDentist.com

PATIENT HEALTH QUESTIONNAIRE

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

		If Yes, Please Explain:
Are you under a physician's care now?	O Yes O No	
Have you ever been hospitalized or had a major operation?	O Yes O No	
Have you ever had a serious head or neck injury?	O Yes O No	
Are you taking any medications, pills, or drugs?	O Yes O No	
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	
Are you on a special diet?	O Yes O No	
Do you use tobacco?	O Yes O No	
Do you use controlled substances?	O Yes O No	
Have you ever had to have pre-medication prior to a dental appt.?	O Yes O No	
Do you believe your immune system may be suppressed?	O Yes O No	
Is there anything you wish to speak about in private with Dr. Pratt?	O Yes O No	

Women: are you pregnant/ Trying to get pregnant? O Yes O No

are you taking oral contraceptives? O Yes O No

Nursing? O Yes O No

Are you allergic or had a reaction to any of the following?

Local Anesthetics _____ Sulfa Drugs _____

Penicillin _____ Other Antibiotics _____

Iodine _____ Asprin _____

Codeine _____ Latex Rubber _____

Bleach _____ Other _____

Any Metals (Mercury, Nickel, etc.) _____

Do you have, or have you had any of the following?

Alzheimer's Disease	O Yes O No	*Diabetes*	O Yes O No	*Hepatitis A*	O Yes O No	*Rheumatic Fever*	O Yes O No
Anphytaxis	O Yes O No	*Drug Addiction*	O Yes O No	*Hepatitis B & C*	O Yes O No	*Rheumatism*	O Yes O No
Anemia	O Yes O No	*Easily Winded*	O Yes O No	*Herpes*	O Yes O No	*Scarlett Fever*	O Yes O No
Angina	O Yes O No	*Emphysema*	O Yes O No	*High Blood Pressure*	O Yes O No	*Shingles*	O Yes O No
Arthretis/Gout	O Yes O No	*Epilepsy or Seizures*	O Yes O No	*Hives or Rash*	O Yes O No	*Sickle Cell Disease*	O Yes O No
Artificial Heart Valve	O Yes O No	*Excessive Bleeding*	O Yes O No	*Hypoglycemia*	O Yes O No	*Sinus Trouble*	O Yes O No
Artificial Joint	O Yes O No	*Excessive Thirst*	O Yes O No	*Irregular Heartbeat*	O Yes O No	*Spina Bifada*	O Yes O No
Asthetics	O Yes O No	*Fainting Spell & Dizziness*	O Yes O No	*Kidney Problems*	O Yes O No	*Stomach Intestinal Disease*	O Yes O No
Blood Disease	O Yes O No	*Frequent Cough*	O Yes O No	*Leukemia*	O Yes O No	*Stroke*	O Yes O No
Blood Transfusion	O Yes O No	*Frequent Diarrhea*	O Yes O No	*Liver Disease*	O Yes O No	*Swelling of Limbs*	O Yes O No
Breathing Problems	O Yes O No	*Frequent Headaches*	O Yes O No	*Low Blood Pressure*	O Yes O No	*Thyroid Disease*	O Yes O No
Bruise Easily	O Yes O No	*Genital Herpes*	O Yes O No	*Lung Disease*	O Yes O No	*Tonsilitis*	O Yes O No
Cancer	O Yes O No	*Glaucoma*	O Yes O No	*Mitral Valve Prolapse*	O Yes O No	*Tuberculosis*	O Yes O No
Chemotherapy	O Yes O No	*Hay Fever*	O Yes O No	*Pain in Jaw Joints*	O Yes O No	*Tumors or Growths*	O Yes O No
Chest Pains	O Yes O No	*Heart Attack/Failure*	O Yes O No	*Parathyroid Disease*	O Yes O No	*Ulcers*	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	*Heart Murmur*	O Yes O No	*Psychiatric Care*	O Yes O No	*Venereal Disease*	O Yes O No
Congenital Heart Disorder	O Yes O No	*Heart Pace Maker*	O Yes O No	*Radiation Treatments*	O Yes O No	*Yellow Jaundice*	O Yes O No
Convulsions	O Yes O No	*Heart Trouble/Disease*	O Yes O No	*Recent Weight Loss*	O Yes O No		
Cortison Medicine	O Yes O No	*Hemophilia*	O Yes O No	*Renal Dialysis*	O Yes O No		

Do you have any medical or dental problems not listed above that you think we should know about? O Yes O No

If, Yes, please explain: _____

I understand the information I provide on this form is essential to determine my dental needs and the provision of treatment. I understand that providing incorrect information can be dangerous to my health. I understand that if any change occurs in my health I must report it to the office as soon as possible. I have read and understand these questions and answered them all truthfully and to the best of my ability, and I have had an opportunity to discuss my health history with Dr. Pratt. I authorize Dr. Pratt to release any information including the diagnosis and the records of any treatment rendered to me or my child to third party payors or health practitioners.

Signature _____ Date _____

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