KENNETH R. JAMES, D.D.S., P.S.
GEORGE J. GOSZTOLA, D.D.S.
940 North Central Avenue, Suite C, Kent, WA 98032
(253) 854-3650

PATIENT REGISTRATION

Patient's Name: _____ Today's Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Patient's Relationship to Person Responsible for Bill: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Date of Birth: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Sex: ❑ Male ❑ Female Soc. Sec. #: _____ Driver's Lic. #: _____

Referred to this Office by: _____

Patient's Employer: _____ Spouse's Name: _____

Address: _____ Spouse's Employer: _____

Work Phone: _____ Work Phone: _____

Occupation: _____ Occupation: _____

PERSON RESPONSIBLE FOR BILL IF NOT PATIENT

Name: _____ Spouse's Name: _____

Address: _____ Spouse's Employer: _____

Home Phone: _____ Work Phone: _____ Address: _____

Date of Birth: _____ Soc. Sec. #: _____ Work Phone: _____

Employer: _____ Address: _____

Address: _____ Occupation: _____

Occupation: _____

INSURANCE INFORMATION

Insurance: _____ Insurance: _____

Address: _____ Address: _____

_____ Phone: _____ _____ Phone: _____

Subscriber's Name: _____ Subscriber's Name: _____

Soc. Sec. #: _____ Birthdate: _____ Soc. Sec. #: _____ Birthdate: _____

Group #: _____ Group #: _____

Subscriber's Employer: _____ Subscriber's Employer: _____

Patient's Relationship to Subscriber: Patient's Relationship to Subscriber:

❑ Self ❑ Spouse ❑ Child ❑ Other: _____ ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

SIGNATURE ON FILE: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PROVIDER OF THESE SERVICES. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE AFTER THE INSURANCE PAYMENT, INCLUDING SERVICES THAT ARE NOT COVERED BY MY INSURANCE PLAN. I AUTHORIZE THE DOCTOR OR THE INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED.

DIVORCED PARENTS: IT IS THE POLICY OF THIS OFFICE THAT THE PARENT ACCOMPANYING THE CHILD FOR TREATMENT IS RESPONSIBLE FOR PAYMENT WE CAN NOT BILL THE OTHER PARENT

SIGNATURE OF PATIENT OR GUARDIAN: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY
(Local friend or relative not living at the same address)

Name: _____ Home Phone: _____

Relationship to Patient: _____ Work Phone: _____

DENTAL HEALTH HISTORY

Today's Date: _____

Patient Name: _____ Birthdate: _____
LAST FIRST INITIAL

DENTAL HISTORY

Reason for today's visit: _____

Former dentist: _____ Address: _____

Date of last dental care: _____ Date of last dental X-rays: _____

Check (X) if you have had problems with any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking painful jaw
- ❑ Food collecting between teeth
- ❑ Clenching or Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How many times per week do you floss? _____ How many times per day do you brush? _____

MEDICAL HISTORY

Physician's name: _____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing?: ❑ Yes ❑ No

Check (4) if you have any of the following:

- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Pacemaker
- ❑ Mitral Valve Prolapse
- ❑ Hemophilia
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Lung Disease
- ❑ Other? _____

Is there any reason why you could not have dentistry performed? _____

Anything else to share with us? _____

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates
- ❑ Codeine
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ (Sleeping Pills)
- ❑ Other: _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____

CREDIT

FOR THE PURPOSE OF CREDIT, I AGREE TO ALLOW DR. JAMES'/ DR. GOSZTOLA'S OFFICE TO OBTAIN A CREDIT REPORT BY SIGNING BELOW.

WITHOUT PATIENT SIGNATURE, THE PATIENT'S PORTION WILL BE DUE@TIME OF SERVICE.

ALL ACCOUNTS PAST 60 DAYS WILL BE ASSESSED A 1.5% FINANCE CHARGE.

Signature _____

Date _____

HEALTH HISTORY UPDATES

_____

_____

_____

_____

_____

_____

_____