Patient Registration & Medical History
Robert Bey, D.D.S. and Gloria Tengonciang, D.M.D.

Date _____

Patient's Name _____ Phone _____

Preferred Name _____ Cell Phone _____

Address _____ City _____ Zip _____

Sex: ❑ M ❑ F Age _____ Birth Date _____ Email Address _____

Social Security # _____ Marital Status _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Name of Spouse/Parent _____ Spouse/Parent Contact Number _____

Spouse/Parent Employer _____ Is insurance through them? Yes ❑ No ❑

Who is responsible for this account? _____ Relationship to patient _____

Who referred you to our office? _____

INSURANCE INFORMATION

Dental Insurance Co. _____

Member ID _____ Insured's Date of Birth _____

Insured's S.S. # _____

FAMILY MEMBERS IN OUR CARE

_____

_____

_____

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Are you taking any medications at this time? (please list) _____

_____

_____

Have you ever had? (please circle)

High/Low Blood Pressure	Anemia	Sinus Trouble
Heart Attack	Diabetes	Asthma or Hay Fever
Heart Surgery	Epilepsy	Headaches
Heart Murmur/Mitral Valve Prolapse	Tuberculosis/Lung Disease	Artificial Joints or Implants
Congenital Heart Problems	Ulcer	Kidney Disease
Artificial Heart Valve	Cancer	Thyroid Disease
Heart Pacemaker	Oral Cancer	Arthritis
Congestive Heart Disease	Drug/Alcohol Dependency	Vertigo
Rheumatic Fever/Heart Disease	HIV Infection (AIDS)	Herpes
Stroke	Hepatitis	COVID-19
Eye Disease	Liver Disease	COVID Vaccination

Are you subject to prolonged bleeding? Yes ❑ No ❑

Are you allergic to: ❑ Penicillin ❑ Latex ❑ Codeine ❑ Anesthetics ❑ Other Medications

Do you smoke or use tobacco products in any form? _____

Have you ever responded adversely to medical or dental treatment? _____

Is there anything else we should know about your medical history? _____

Women: Are you pregnant? Yes ❑ No ❑ How many weeks? _____

Are you nursing? Yes ❑ No ❑

Are you happy with your smile? _____ If not, why? _____

Do you ever have jaw joint (TMJ) pain? _____

Signature _____ *Please read other side* →

Financial Policy

We appreciate payment when services are rendered

Your account is to be paid in full within 30 days of receipt of your statement unless other arrangements have been made with our office.

Charges not paid within 30 days of receipt of your statement are subject to a finance charge of 1.50% per month (18% annual rate).

To our patients with insurance

As a courtesy to you, we will complete and file insurance forms for your dental treatment. *You are responsible for verifying benefits and coverage percentages*. When benefits are assigned to us, we ask that you pay the *estimated* amount the insurance company will not cover (your deductible and co-pay) at the time of service. Balances outstanding 30 days after payment by the insurance company will be subject to a finance charge of 1.50% per month (18% annual rate) unless prior arrangements have been made. The ultimate responsibility for this account remains yours. ln the event of an extended insurance delay or disputed claim, we may require your immediate payment of the balance.

I have read and understand the above financial policy.

_____ _____

Signature Date

I consent to receiving from the dental practice email and/or communications regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

My preferred method of contact is:

E-mail ❑ Cell Phone ❑

My email address is: _____

My cell phone number is: _____