T. ALAN LYLE D.D.S. P.C
REGISTRATION

Date: _____

PATIENT INFORMATION

Name: _____
First Middle Last

Birthday:_____/_____/_____ Social Security #_____-____-_____ Sex: M or F
Mailing Address:_____ City: _____State: _____
Zip:_____ Home Tel: (_____)_____ Cell: (_____)_____

Please Circle One: Minor Single Married Divorced Widowed Separated

Name of Employer: _____ Address:_____
City _____ State_____ Work Tel: (_____)_____

If Student, Name of School/College: _____City: _____
State: _____ Choose One: Full Time or Part Time

I hereby authorize and request the performance of dental services for myself or
for:_____ age:_____

RESPONSIBLE PARTY INFORMATION (PARENT OF MINOR CHILD)

Name:_____
First Middle Last

Relationship to Patient: _____ Is this person a patient in this office: Yes or No

Birthday:_____/_____/_____ Social Security #_____-____-_____ Sex: M or F
Mailing Address:_____ City: _____State: _____
Zip:_____ Home Tel: (_____)_____ Cell: (_____)_____

Name of Employer: _____ Address:_____
City _____ State_____ Work Tel: (_____)_____

INSURANCE INFORMATION

Name of Insured:_____
First Middle Last
Relationship to Patient: _____ Is this person a patient in this office: Yes or No

Birthday:_____/_____/_____ Social Security #_____-____-_____ Sex: M or F
Mailing Address:_____ City: _____State: _____
Zip:_____ Home Tel: (_____)_____ Cell: (_____)_____

Name of Employer: _____ Address:_____
City _____ State_____ Work Tel: (_____)_____

EMERGENCY CONTACT (SEPARATE FROM HOME INFORMATION)

Name of emergency contact_____
Relationship to patient_____ Home Tel: (____)_____ Cell: (____)_____

PATIENT MEDICAL HISTORY

Name of Physician: _____ Physician Tel: (____)_____

List any known allergies: _____

Are you under a physician's care at the present time? (circle one) Yes or No
If Yes, please write reason for treatment: _____
_____

Are you pregnant? (circle one) Yes or No If Yes, how many weeks? _____

Are you taking any medication at this time? (circle one) Yes or No
If Yes, please write the name of the medication(s) and the conditions being treated.

Medication	Reason for Medication
_____	_____
_____	_____
_____	_____
_____	_____

Please circle any illnesses you have or have ever had:

Allergies	Tuberculosis	Anemia	Kidney or Liver
Diabetes	Rheumatic Fever	Heart Trouble	Asthma
Epilepsy	Hepatitis	Glaucoma	HIV or AIDS
Osteoporosis	High Blood Pressure	Other_____	

Have you ever had trouble with bleeding after surgery or dental work? _____
Have you ever had any unusual reaction to an anesthetic or drug? _____
Is there any other information about your health we should know? _____
Is there any other information about your dental health we should know? _____

I am aware of the broken appointment fee that I will be charged if any appointment is cancelled, rescheduled, or broken without 24-hour notice. _____(initial)

I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

I have been informed by you, of your HIPPA notice of privacy practices and I consent to legal uses of my health information.

I hereby authorize payment of insurance dental benefits directly to the dentist.

Signature_____ Date _____