Please Print

# PATIENT REGISTRATION

Patient__________ Date of Birth__________

How would you like to be addressed; by your first name, last name or nickname? __________

Married - Spouse's Name__________ Single___ Widowed___ Divorced___

Address__________Apt. #____ City__________ State______ Zip______

Home Phone_______Cell_______Business_______Preferred E-mail address__________

Referred By__________Best number to reach you __________

Non-household resident to notify in case of emergency:

Name__________Phone__________

## MEDICAL HISTORY

1. Date of last physical exam_______ 2. Physician name__________Phone_______

3. Have you ever had a serious illness?_______ 4. Are you under medical treatment?__________

Are you or do you believe you might be pregnant?_______

5. Are you now taking any medication?_____If so, names and dosage__________

6. Has a physician ever informed you that you had a heart ailment?_______

____Low Blood Pressure ____High Blood Pressure_____/_____(average) ____Heart Murmur ____Valve or joint replacement

7. Has a physician ever informed you that you had rheumatic fever?__________

8. Has a physician ever informed you that you had hepatitis (liver disease)?____ HIV Positive___ Aids___

Venereal disease____ Anemia____ Glaucoma____ Tuberculosis____ Other__________

9. To your knowledge are you allergic to anything?__________

10. Have you ever bled excessively?______11. When did you last see a dentist?__________

12. Did complications arise following any previous extractions?__________

13. Are you uncomfortable about dental treatment?__________

14. How do you feel about your teeth?__________

## FINANCIAL INFORMATION

Responsible Person for Payment__________Relationship to Patient_______

PRINT FULL NAME

Secondary Insurance Subscriber__________

Birthdate__________Social Security #__________

Employer__________

Subscriber's Birthdate__________Subscriber's SS#__________

Subscriber's Employer__________

## INSURANCE INFORMATION

| Insurance Subscriber | Secondary Subscriber |
|---|---|
| 1. Insurance Co.__________ | 1. Insurance Co.__________ |
| 2. Policy #__________ | 2. Policy #__________ |
| 3. Benefit Period__________ | 3. Benefit Period__________ |
| 4. Maximum Deductible__________ | 4. Maximum Deductible__________ |
| 5. Deductible__________ | 5. Deductible__________ |
| 6. Coverage Percent | 6. Coverage Percent |
| a. Preventative__________ | a. Preventative__________ |
| b. Basic__________ | b. Basic__________ |
| c. Major__________ | c. Major__________ |
| 7. Exclusions__________ | 7. Exclusions__________ |

I hereby authorize payment to the below-named dentist of the group insurance benefits otherwise payable to me.

WILLIAM M. BETHEL, D.D.S.

_______________________________________________________________________________

SIGNED (INSURED PERSON) DATE

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. I also agree to pay a 1% finance charge on any balance older than 30 days. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such cost as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.(A Copy of this assignment is as valid as the original.)

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of the agreement at the time you sign. Keep it for your legal rights. I agree to pay for any treatment necessary, not chargeable to the insurance.___________ initials

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification.

Signature_______________________________________________________________________

PERSON RESPONSIBLE FOR PAYMENT DATE

Dr. William M. Bethel DDS PS 10700 SE 174th Suite #201, Renton, WA 98055 Phone: 425-226-3230 Fax: 425-226-7350