

**RANDALL E. KNUTH, D.D.S.**  
**SHAWN M. MCFARLAND, D.D.S.**

**PATIENT REGISTRATION**  
(TO BE FILLED IN COMPLETELY - PLEASE PRINT)

**PATIENT INFORMATION**

FULL NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ EMAIL \_\_\_\_\_  
SOCIAL SECURITY NO. \_\_\_\_\_ DRIVER'S LICENSE NO. \_\_\_\_\_  
SEX  MALE  FEMALE MARITAL STATUS  SINGLE  MARRIED  DIVORCED  WIDOWED  
EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_  
FULL TIME STUDENT YES NO NAME OF SCHOOL \_\_\_\_\_  
NAME OF SPOUSE \_\_\_\_\_ SPOUSE'S SOCIAL SECURITY NO. \_\_\_\_\_  
SPOUSE'S EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_  
NEARESTST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE \_\_\_\_\_  
FRIEND OR NEIGHBOR IN CASE OF EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_  
REFERRED BY \_\_\_\_\_

**RESPONSIBLE PARTY**

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
DRIVER'S LICENSE # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ SSN# \_\_\_\_\_  
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  YES  NO

**DENTAL INSURANCE INFORMATION**

**PRIMARY INSURANCE CARRIER**

ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE # \_\_\_\_\_  
ID OR POLICYNO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_  
NAME OF POLICY HOLDER \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

**SECONDARY INSURANCE CARRIER**

ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE # \_\_\_\_\_  
ID OR POLICYNO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_  
NAME OF POLICY HOLDER \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_

**PLEASE NOTE**

OUR OFFICE BILLS INDIVIDUALS IN THE SAME HOUSEHOLD UNDER **ONE** ACCOUNT. IF YOU MUST HAVE SEPARATE ACCOUNTS PLEASE NOTIFY THE RECEPTIONIST.

PAYMENT IS DUE UPON RECEIPT OF SERVICES UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. AS A COURTESY TO OUR PATIENTS. WE WILL FILE PRIVATE DENTAL INSURANCE CLAIMS; HOWEVER. THE CO-PAYMENT AND ANY DEDUCTIBLE SPECIFIED BY YOUR PLAN ARE DUE AT THE TIME OF SERVICE. PLEASE REMEMBER THAT YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF THE FEES IN THIS OFFICE. PAYMENTS MAY BE MADE BY CASH, CHECK, VISA/MASTERCARD.

**AUTHORIZATION FOR RELEASE OF DENTAL INFORMATION, ASSIGNMENT OF BENEFITS**

I AUTHORIZE RANDALL E.KNUTH, D.D.S. AND SHAWN M. MCFARLAND. D.D.S. TO RELEASE DENTAL INFORMATION FOR INSURANCE PURPOSES CONCERNING TREATMENT OF THE ABOVE NAMED PATIENT WHILE UNDER HIS CARE. I AUTHORIZE PAYMENT OF ANY INSURANCE BENEFITS FOR DENTAL SERVICES DIRECTLY TO RANDALL E. KNUTH. D.D.S. AND SHAWN M. MCFARLAND. D.D.S. I AGREE TO PAY ANY FEES NOT COVERED BY INSURANCE BENEFITS DIRECTLY TO RANDALL E. KNUTH. D.D.S. AND SHAWN M. MCFARLAND. D.D.S. UPON DEFAULT, I AGREE TO PAY INTEREST OF 1.75% PER MONTH. 21% A.P.R. IF PAYMENT ARRANGEMENTS HAVE BEEN EXTENDED LONGER THAN 90 DAYS, I UNDERSTAND THAT A \$25 PER MONTH STATEMENT FEE WILL BE CHARGED TO MY ACCOUNT. IF THIS ACCOUNT IS REFERRED FOR COLLECTION, I AGREE TO PAY A 33% COLLECTION FEE ON THE AMOUNT OWING. SHOULD LEGAL ACTION BE TAKEN. I AGREE TO PAY REASONABLE ATTORNEY'S FEES AND COURT COSTS IN ADDITION TO THE ABOVE AMOUNTS.

A CHARGE WILL BE MADE FOR CANCELLATIONS WITHOUT 48 HOURS NOTICE ON APPOINTMENTS.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

**MEDICAL HISTORY**

NAME OF PHYSICIAN \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

PLEASE LIST ANY MEDICATIONS CURRENTLY BEING TAKEN \_\_\_\_\_

PLEASE LIST ANY MEDICATIONS PATIENT IS ALLERGIC TO \_\_\_\_\_

HAS THE PATIENT EVER HAD AN UNUSUAL REACTION TO DENTAL ANESTHESIA? .....  YES  NO

IS THE PATIENT IN GOOD HEALTH? .....  YES  NO

- |                       |  |                          |  |                       |  |
|-----------------------|--|--------------------------|--|-----------------------|--|
| AIDS/H.I.V. POSITIVE  | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEART PACEMAKER          | <input type="checkbox"/> YES <input type="checkbox"/> NO | MITRAL VALVE PROLAPSE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ANEMIA                | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEART (SURGERY,          | <input type="checkbox"/> YES <input type="checkbox"/> NO | NERVOUS DISORDERS     | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ASTHMA                | <input type="checkbox"/> YES <input type="checkbox"/> NO | DISEASE, ATTACK)         | <input type="checkbox"/> YES <input type="checkbox"/> NO | PROLONGED BLEEDING    | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| BYPASS GRAFT          | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEART TROUBLE            | <input type="checkbox"/> YES <input type="checkbox"/> NO | RADIATION THERAPY     | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CHEMOTHERAPY          | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEPATITIS A (INFECTIOUS) | <input type="checkbox"/> YES <input type="checkbox"/> NO | RHEUMATIC FEVER       | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CHRONIC COUGH         | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEPATITIS B (SERUM)      | <input type="checkbox"/> YES <input type="checkbox"/> NO | SINUS TROUBLE         | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DIABETES              | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEPATITIS C (SERUM)      | <input type="checkbox"/> YES <input type="checkbox"/> NO | SMOKE CURRENTLY       | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ENDOCRINE PROBLEMS    | <input type="checkbox"/> YES <input type="checkbox"/> NO | HIGH BLOOD PRESSURE      | <input type="checkbox"/> YES <input type="checkbox"/> NO | SPECIAL DIET          | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| EPILEPSY              | <input type="checkbox"/> YES <input type="checkbox"/> NO | JOINT REPLACEMENT        | <input type="checkbox"/> YES <input type="checkbox"/> NO | STROKE                | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| FAINTING OR DIZZINESS | <input type="checkbox"/> YES <input type="checkbox"/> NO | KIDNEY INVOLVEMENT       | <input type="checkbox"/> YES <input type="checkbox"/> NO | TUBERCULOSIS          | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HEART MURMUR          | <input type="checkbox"/> YES <input type="checkbox"/> NO | LATEX SENSITIVITY        | <input type="checkbox"/> YES <input type="checkbox"/> NO | .....                 | <input type="checkbox"/> YES <input type="checkbox"/> NO |

WOMEN. ARE YOU: PREGNANT? YES, \_\_\_\_\_MONTHS NO NURSING? YES NO TAKING BIRTH CONTROL PILLS? YES NO

DO YOU HAVE OR HAVE YOU HAD ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? .....  YES  NO

IF YES, PLEASE LIST: \_\_\_\_\_

DATE REVIEWED \_\_\_\_\_ INITIALS \_\_\_\_\_ DATE REVIEWED \_\_\_\_\_ INITIALS \_\_\_\_\_ DATE REVIEWED \_\_\_\_\_ INITIALS \_\_\_\_\_

**DENTAL HISTORY**

REASON FOR VISIT TO THIS OFFICE? \_\_\_\_\_

HOW LONG SINCE YOUR LAST DENTAL VISIT? \_\_\_\_\_

DO YOU HAVE ANY DISCOMFORT? \_\_\_\_\_  YES  NO

ARE TEETH SENSITIVE TO  HEAT  COLD  PRESSURE  SWEETS?  \_\_\_\_\_

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH, TEETH? .....  YES  NO

DO YOU MAKE REGULAR VISITS TO THE DENTIST? .....  YES  NO

ARE YOU FRIGHTENED DURING DENTAL VISITS? .....  YES  NO

DO YOU PREFER A LOCAL ANESTHETIC (NOVOCAINE) FOR DENTAL PROCEDURES? .....  YES  NO

DO YOU GAG EASILY? .....  YES  NO

DO YOUR GUMS BLEED EASILY? .....  YES  NO

HAVE YOU EVER HAD PERIODONTAL TREATMENT? .....  YES  NO

DO YOU HAVE CLICKING, POPPING OR PAIN WHEN OPENING OR CLOSING JAWS? .....  YES  NO

ARE YOU INTERESTED IN WHITENING YOUR TEETH? .....  YES  NO

ON A SCALE FROM 1 TO 10, 10 BEING THE BEST, HOW DO YOU LIKE THE APPEARANCE OF YOUR TEETH (CIRCLE ONE) 1 2 3 4 5 6 7 8 9 10  
LEAST BEST

**CONSENT FOR TREATMENT**

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_ 's dental needs.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If payment arrangements have been extended longer than 90 days, I understand that a \$25 per month statement fee will be charged to my account. In the event payments are not received by agreed upon dates, I understand that a 1.75% late charge (21% APR) may be added to my account.

Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_