WELCOME

TO

BMP DENTAL, PA / BELA PATEL, D.D.S.

4020 Hedgcoxe Road, Suite 500, Plano, TX 75024
(972) 618 - 4757, www.bmpdental.com

PATIENT REGISTRATION FORM

Referral Source: _____ Patient Phone # _____

Email Address: _____

NEW PATIENT INFORMATION

Patient_____, _____. _____
Last Name First Name Middle Name Preferred Name

Sex ____Male _____ Female Date of Birth_____ Age _____
____Married _____ Widowed _____Single ____Minor
____Separated _____ Divorced _____ Partnered for _____ years

Home Phone # _____ Cell Phone #_____

Work Phone# _____ Other Phone# _____

Street Address_____ Apt. #_____

City _____ State _____ Zip _____

DENTAL HISTORY:

Reason for today's visit: _____

Name of Former Dentist _____Date of last visit _____
Date of last dental X-rays _____
Have you experienced any of the following? :
(Please check all responses that apply)

Cold Sensitivity	____ Yes	_____No	Bad Breath	_____ Yes	_____No
Sweet Sensitivity	____ Yes	_____No	Bleeding Gums	_____Yes	_____No
Heat Sensitivity	____Yes	_____No	Loose Teeth	_____ Yes	_____No
Biting Sensitivity	____Yes	_____ No	Gum Treatment	_____Yes	_____ No
Broken Fillings	____Yes	_____ No	Grinding Teeth	_____Yes	_____ No
Food Collection	____Yes	_____No	Jaw-Joint/ TMJ pain	_____Yes	_____ No

How frequent do you brush? _____ & Floss? _____
Have you ever responded adversely to any dental treatment? _____No, if Yes Please Explain_____

_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication, anesthetic, materials or latex gloves?

No_____ Yes, _____ what materials or drugs? _____

RESPONSIBLE PARTY INFO: Name _____Relationship_____

Social Security #_____- _____-_____ Driver's License: _____ State_____

Home Phone # _____ Cell Phone # _____

Address if different than above: _____

Employer / School _____ Full time student? Yes ____ No____

Occupation _____Employer / School phone _____

Spouse/ Parent Name _____ Date of Birth _____

Spouse/ Parent Employed by _____ Occupation _____

Business Address _____Phone _____

RESPONSIBLE DENTAL INSURANCE CO. _____

Subscriber's Name _____ Date of Birth _____

Subscriber's SS#_____ Subscriber's ID #_____

Subscriber's address if different than above: _____

Who may we thank for referring you? _____

Today's visit will be paid by: _____Cash _____ Check _____ Credit Card _____

OFFICIAL FINANCIAL AGREEMENT:

All returned checks must be paid in cash within 10 days with a service charge of $25.00. Dental insurance can be processed with the following conditions: The office must be able to verify coverage or entire payment for services will need to be paid at the current appointment. Secondary insurance can be filed for you, but you will be responsible for paying this as most secondary insurance is sent directly to the subscriber. *Any charges not paid by the insurance remain the responsibility of the patient. A dental plan is nothing more than a contract between the employer and the insurance company to partially pay for certain services. We will file your insurance as a courtesy for our patients, with the mutual understanding, that all fees unpaid by the insurance company are the immediate responsibility of the patient.*

I, the undersigned certify that I (or my dependent) have dental insurance, and assign directly to BMP Dental, P.A. (or Bela Patel, D.D.S.), all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I grant my permission to you, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content. If I am unable to keep the appointment, I realize that a 24-hour notice is required. Without proper notification, I will agree to pay the current office visit charge.

Signature _____ Date _____

MEDICAL HISTORY:

Medical History for _____ Age _____ Date of Birth _____

Physician's Name_____ Date of last Physical_____

Hospitalizations: _____

Complications from any medical problems or hospitalizations:_____

Have you ever had any of the following (check only those that apply):

___Allergies
___Arthritis or Rheumatism
___Artificial Heart Valves, Screws, etc.
___Artificial Joints
___Asthma
___Back Problems
___Bleeding Abnormally
___Blood Disease
___Blood Transfusion
___Cancer
___Chemical Dependency
___Chemotherapy
___Chest Pains
___Chronic Diarrhea
___Circulatory Problems
___Congenital heart lesions
___Cortisone-Steroid Treatment
___Diabetes
___Epilepsy, Convulsions or Seizures
___Glaucoma
___Headaches
___Heart Murmur
___Heart Problems
___Hemophilia
___Hepatitis, Jaundice or Liver Disease
___Hernia Repair
___High Blood Pressure
___HIV/AIDS+
___Kidney or bladder Disease
___Low Blood Pressure
___Mitral Valve Prolapse
__Nervous Problems
___Pacemaker
___Psychiatric Care
___Radiation Treatment
___Recent Weight Loss
___Respiratory Disease
___Rheumatic Fever
___Shortness of Breath
___Sinus Problems/Hayfever
___Special Diet
___Stroke
___Swollen Neck Glands
___Swollen Ankles
___Thyroid Trouble
___Ulcer
___Venereal Disease

Have you ever taken pre-treatment antibiotics? _____

Have you ever responded adversely to medical or dental treatment? _____Yes (please explain)_____No

Are you taking any medication at this time? _____ If so, what? (Attach list)_____

Have you ever taken any of drugs collectively referred to as Fen-Phen?"

These include combination of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) _____Yes _____No

**Do you have any drug allergies or have you ever had an adverse reaction to any medication, anesthetic, materials, or latex gloves? Yes No If so, what materials or drugs?_____

Have you ever had a bleeding problem? _____

Do you use tobacco products? _____

Do you have a history of fainting?_____

Are you under the care of a physician? ____Yes ____No For what conditions?_____

MEDICAL HISTORY (Continued) :

If patient is a child, what is his/her weight? _____

Women – Do you suspect that you are pregnant? _____ Yes ____No Due Date _____

Are you nursing? ____ Yes ____No Taking birth control pills ____Yes ___No

Do you have any disease or condition not listed or anything about your health problem that we have not covered? _____ No _____ Yes, if yes, please list:_____

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

Emergency Information: Please list the names and telephone numbers or two relatives (or friends) not living with you, so that we may contact in the case of an emergency:

Name _____Relation_____ Name _____Relation_____

Address_____ Address_____

Phone ( ) _____-_____ Phone ( ) _____- _____

RELEASE: I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I AM RESPONSIBLE TO INFORM THIS OFFICE OF ANY CAHNGE IN HEALTH HISTORY.

Signature:_____ Date:_____

_____ Date:_____

Doctor's Signature