PATIENT REGISTRATION

Complete and click submit at the bottom of page or print out and return to receptionist.

Gary J. Warr, D.D.S.
Beacon Square Medical Village
21701 W. 11 Mile Rd. | Suite One
Southfield, MI | 48076 | 248-353-6688

Patient's Name: _____ Birthdate: _____ S.S. #: _____

Address: _____ City: _____ Zip: _____ Driver's License #: _____

Age: _____ Gender: Male ❑ Female ❑ Marital Status: Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑

CONTACT INFO.: Home Phone: Cellular Phone: E-mail Address: Fax:

Employer: _____ Occupation: _____ Years Employed: _____

Address: _____ City: _____ Zip: _____ Work Phone: _____

Spouse's/Parent's Name: _____ Birthdate: _____ S.S. #: _____

Employer: _____ Occupation: _____ Years Employed: _____

Address: _____ City: _____ Zip: _____ Work Phone: _____

INSURANCE INFORMATION

Policy Name: _____ Group #: _____

Subscriber's Name: _____ Birthdate: _____ S.S.#: _____

Second Policy Name: _____ Group #: _____

Subscriber's Name: _____ Birthdate: _____ S.S.#: _____

In case of emergency who do we notify? _____ Phone: _____

Whom can we thank for referring you? _____

Who will pay for this account? _____

Reason for visit: _____

HEALTH HISTORY

Are you presently under the care of a Physician? Y N

If yes what for? _____

Dr.'s Name: _____ Phone: _____

Have you ever had any of the following?

Cortisone	Y N	**High Blood Pressure**	Y N
Rheumatic/Scarlet Fever	Y N	**Diabetes**	Y N
Bleeding problems	Y N	**Radiation Treatment**	Y N
Any kind of seizures	Y N	**Fainting**	Y N
Heart Murmur	Y N	**Tuberculosis**	Y N
Asthma	Y N	**Hepatitis**	Y N
Aids	Y N	**Pacemaker**	Y N
Allergies	Y N	**List** _____	
Reaction to any drugs?	Y N	**List** _____	
Are you on any medication?	Y N	**List** _____	
Are you pregnant?	Y N	**How many months?** _____	
Are you anemic?	Y N		

Do you have any artificial joints or heart valve? _____

For All Patients

I hereby authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, a full explanation of the procedures(s) involved will be given by the doctor and/or his staff. I agree to pay for all the services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment reminder items sent via mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in this office.

_____

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

Click Here to Submit by e-mail