PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

1

DATE

LAST NAME | FIRST | M.I.

PREFERS TO BE CALLED BY

ADDRESS

ADDRESS 2

CITY | STATE | ZIP

HOME PHONE NO.

CELL | WORK PHONE

EMAIL

PREFERRED METHOD OF CONTACT:
[ ] HOME PHONE [ ] CELL [ ] WORK PHONE [ ] EMAIL [ ] TEXT

BIRTHDATE | AGE | GENDER: [ ] MALE [ ] FEMALE

FAMILY STATUS:
[ ] CHILD [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED

SCHOOL (IF APPLICABLE) | GRADE

CITY | STATE

SOCIAL SECURITY NO.

2

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | PATIENT'S RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUSE [ ] CHILD

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | PATIENT'S RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUSE [ ] CHILD

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

3

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?
NAME | RELATIONSHIP

YOU WERE REFERRED TO US BY

PERSON TO CONTACT FOR EMERGENCY

RELATIONSHIP

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

RELATIONSHIP

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

4

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO.

ADDRESS

CITY | STATE | ZIP

PHONE NO.

YOU

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. 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.

3. 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.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. 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. In the event payments are not received by agreed upon dates, I understand that a 1-1 /2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Parent/Guardian Name: _____ Witness Name: _____
(if patient is a minor)

DENTAL HISTORY

PATIENT NAME (Last, First)		
DATE OF BIRTH	PATIENT ACCOUNT NO. (OFFICE ONLY)	MEDICAL ALERT (OFFICE ONLY)

Welcome! *So that we may provide you with the best possible care, please complete this form and the medical history form. All information is completely confidential.*

What is the reason for your visit today?

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit?

_____

Previous Dentist's Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

How often do you have dental cleanings and examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Sonicare, waterpik, interdental brushes, etc.) _____

Do you have any dental problems now? ◯ Yes ◯ No

If yes, please describe: _____

Are any of your teeth sensitive to:	**Y**	**N**
Hot or cold?	◯	◯
Sweets?	◯	◯
Biting or Chewing?	◯	◯
Have you noticed any mouth odors or bad tastes?	◯	◯
Do you frequently get cold sores, blisters, or any other oral lesions?	◯	◯
Do your gums bleed when you brush or floss?	◯	◯
Do you have dry mouth?	◯	◯
Have you noticed any loose teeth or change in your bite?	◯	◯
Does food tend to become caught in between your teeth?	◯	◯

If yes, where? _____

Do you:	**Y**	**N**
Clench or grind your teeth while awake or asleep?	◯	◯
Bite your lips or cheeks regularly?	◯	◯
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	◯	◯
Mouth breathe while awake or asleep?	◯	◯
Have tired jaws, especially in the morning?	◯	◯
Snore or have any other sleeping disorders?	◯	◯
Smoke/chew tobacco or use other tobacco products?	◯	◯

Have you ever had:	**Y**	**N**
Orthodontic treatment?	◯	◯
Oral surgery?	◯	◯
Periodontal treatment?	◯	◯
Your teeth ground or the bite adjusted?	◯	◯
A bite plate or mouth guard?	◯	◯
A serious injury to the mouth or head?	◯	◯

If so, please describe, including cause:

_____

Have you experienced:	**Y**	**N**
Clicking or popping of the jaw?	◯	◯
Pain? (joint, ear, side of face)	◯	◯
Difficulty in opening or closing the mouth?	◯	◯
Difficulty in chewing on either side of the mouth?	◯	◯
Headaches, neckaches or shoulder aches?	◯	◯
Sore muscles (neck or shoulders)?	◯	◯
Are you satisfied with your teeth's appearance?	◯	◯

If not, what would you like to change?

_____

Do you feel nervous about having dental treatment? ◯ ◯

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? ◯ ◯

If yes, please describe:

_____

Is there anything else about having dental treatment that you would like us to know? ◯ Yes ◯ No

If yes, please describe: _____

MEDICAL HISTORY

PATIENT NAME (Last, First)		
DATE OF BIRTH	PATIENT ACCOUNT NO. (OFFICE ONLY)	MEDICAL ALERT (OFFICE ONLY)

	Y	N
1. Have you been under the care of a medical doctor during the past two years?	○	○
If yes, for what? _____		
Physician's Name _____ Telephone _____		
Address _____ City _____ State ____ Zip _____		
2. Would you consider yourself to be in fairly good health?	○	○
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines?	○	○
If yes, please list name of medication:		

MED 1 _____ MED 2 _____ MED 3 _____ MED 4 _____

MED 5 _____ MED 6 _____ MED 7 _____ MED 8 _____

	Y	N
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or similar drugs?	○	○
5. Are you aware of having an allergic (**or adverse**) reaction to any medication or substance?	○	○
If yes, please list: _____		
6. Have you been a patient in the hospital during the past five years?	○	○

7. Indicate which of the following you have had, or have at present. Check **Y** (Yes) or **N** (No) for each item.

	Y	N		Y	N		Y	N
Heart (Surgery, Disease, Attack)	○	○	Ulcers	○	○	Hepatitis __A __B __C	○	○
Chest Pain	○	○	Diabetes	○	○	Venereal Disease	○	○
Congenital Heart Disease	○	○	Thyroid Problems	○	○	A.I.D.S./H.I.V. Positive	○	○
Heart Murmur	○	○	Glaucoma	○	○	Cold Sores/Fever Blisters	○	○
High Blood Pressure	○	○	Contact Lenses	○	○	Blood Transfusion	○	○
Mitral Valve Prolapse	○	○	Emphysema	○	○	Hemophilia	○	○
Artificial Heart Valve	○	○	Chronic Cough	○	○	Sickle Cell Disease	○	○
Heart Pacemaker	○	○	Tuberculosis	○	○	Bruise Easily	○	○
Rheumatic Fever	○	○	Asthma	○	○	Liver Disease	○	○
Arthritis/Rheumatism	○	○	Hay Fever	○	○	Yellow Jaundice	○	○
Cortisone Medicine	○	○	Latex Sensitivity	○	○	Neurological Disorders	○	○
Swollen Ankles	○	○	Allergies or Hives	○	○	Epilepsy or Seizures	○	○
Stroke	○	○	Sinus Trouble	○	○	Fainting or Dizzy Spells	○	○
Diet (Special Restricted)	○	○	Radiation Therapy	○	○	Nervous/Anxious	○	○
Artificial Joints (hip, knee, etc.)	○	○	Chemotherapy	○	○	Psychiatric/Psychological Care	○	○
Kidney Trouble	○	○	Tumors	○	○	Cancer	○	○

	Y	N
8. Do you use more than two pillows to sleep?	○	○
9. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	○	○
10. Do you have or have you had any disease, condition, or problem not listed?	○	○
If yes, please list: _____		

11. **Women:** Are you pregnant or think you may be pregnant? ○ Yes ___Months ○ No
Nursing? ○ Yes ○ No Do you use birth control medications? ○ Yes ○ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

PATIENT/GUARDIAN SIGNATURE DATE: DOCTOR SIGNATURE DATE: