Patient Registration

Personal Information

Name: _____ _____
Last First Mi Mr. Mrs. Ms. Dr.

I prefer to be called: _____ ___ Male ___ Female

Birth date: ____/____/_____ Age: _____ SS#: _____

Address: _____
Apt./Condo

_____
City State Zip

Email Address:
_____

Home #: (____) _____

Cell #: (____) _____

Work #: (____) _____ ext: _____

***Which number would you prefer we use to confirm appointments**? _____

When are the best times to reach you? _____

Employer: _____ Occupation: _____
Employer's Address: _____

Whom may we contact in the case of an emergency?

Name: _____

Relation: _____

Home #: _____

Cell #: _____

Work #: _____

Person responsible for payments on account:
__ Self
__ Parent/Guardian
__ Significant Other

Whom may we thank for referring you?
_____

Other family members seen by us:
_____

Insurance

Do you have dental insurance? ____ Yes ____ No

Primary Dental Insurance

You are insured through your employer, your significant other's employer, or a parent/guardian

Insurance Co. Name: _____
Insurance Co. Address:
_____
_____
Insurance Co. phone #: (___) _____

Group #: _____
(Plan, Local or Policy)

Insured's ID #: _____

If you are not the insured, please specify who is.
Insured's Name: _____

Relation: _____

Insured's Birth date: ____/____/_____

Insured's SS #: _____

Insured's Employer:
_____
Employer's Address: _____
_____

Secondary Dental Insurance

You have <u>additional</u> dental coverage through your significant other

Insurance Co. Name: _____
Insurance Co. Address:
_____
_____
Insurance Co. Phone #: (___) _____

Group #: _____
(Plan, Local or Policy #)

Insured's ID #: _____

Insured's Name: _____

Relation: _____

Insured's Birth date: ____/____/_____

Insured's SS #: _____

Insured's Employer:
_____
Employer's Address: _____
_____

Please read the following statement:

Regardless of whether the treatment I receive is covered by insurance, I understand that I am responsible for all costs of dental services and also responsible for paying any amount, including co-payments and deductibles, that my insurance does not cover. I hereby authorize payment and assign benefits directly to the Dental Office of the group insurance benefits otherwise payable to me. If a balance remains 30 days past the completion date, interest charges may be added at the rate of 1.5 % monthly on the unpaid balance. In the event this office hires an attorney or agency to collect any past due fees owed to this office, I agree to pay any and all reasonable fees, including reasonable attorney fees that are incurred.

_____ _____
Signature Date

Medical History

Physician: _____ Phone Number: (____) _____
Are you currently under the care of a physician? ___ Yes ___ No
If yes, please explain: _____

Pharmacy: _____ Phone Number: (____) _____

Do you require antibiotics before dental treatment? ___ Yes ___ No
Please list any serious medical condition(s) that you have ever had:
_____
Do you have any metal rods, pins or implants? ___ Yes ___ No Where? _____
Do you smoke or use tobacco in any other form? ___ Yes ___ No
If yes, frequency: _____
Have you ever taken Fosomax, or any other bisphosphonate? ___ Yes ___No

For Women: Are you using oral contraceptives? ___ Yes ___ No
Are you pregnant? ___ Yes ___ No Are you nursing? ___ Yes ___ No

Have you ever had any of the following diseases or medical problems?

Y N Abdominal bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones, Joints or Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Disease
Y N Diabetes __ I __ II
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for Any Reason
Describe: _____
_____
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis/Paget's Disease
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Date(s): _____
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Ulcers
Y N Venereal Disease

Medications/Dosage

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other _____

Please list any drugs/materials that you are allergic to:
_____
_____
_____

Dental History

Why have you come to the office today? _____

Date of last dental visit _____

Previous Dentist: _____ phone number: _____

Have you ever had a serious/difficult problem associated with previous dental work?
___ Yes ___ No *If yes, please explain:* _____

Have you ever had gum (periodontal) treatment? ___ Yes ___ No
If yes, please explain: _____

How many times a week do you floss? ____ A day do you brush? ____

Type of toothbrush bristles: ___ Soft ___ Medium ___ Hard

How often do you replace your tooth brush? _____

Do you experience any of the following?

Y	N	Bad Breath	Y	N	Sensitivity to Biting
Y	N	Bleeding Gums	Y	N	Sensitivity to Cold
Y	N	Clenching/Grinding Teeth	Y	N	Sensitivity to Heat
Y	N	Clicking/Popping in Jaw/TMJ	Y	N	Sensitivity to Sweets
Y	N	Dry Mouth	Y	N	Sores in or Around Mouth
Y	N	Jaw/TMJ Pain	Y	N	Tooth/Teeth Pain

Please read the following:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____
Signature Date