

PATIENT REGISTRATION FORM

Please fill out the following confidential information

1 Today's Date mm/dd/year

If this appointment is for you, start here

OR

If this appointment is for your child, start here

Last Name First M.I.

Address

City State Zip

Home Phone No. Fax

Cell Email

Birthdate mm/dd/year Age

Sex Male Female Social Security No. --

Married Single Divorced Widowed

Prefers to be called by

Last Name First M.I.

Address

City State Zip

Home Phone No. Fax

Cell Email

Birthdate mm/dd/year Age

Sex Male Female Social Security No. --

School Grade

If your Child's last name and/or address are NOT the same as yours, please fill out the left side of Part 1 also.

2 Dental Insurance

PRIMARY CARRIER

Insurance Company Group #

Insured's Name Employer Name

Date of Birth mm/dd/year Insured's ID#

Relationship to Patient Social Security No. --

SECONDARY CARRIER

Insurance Company Group #

Insured's Name Employer Name

Date of Birth mm/dd/year Insured's ID#

Relationship to Patient Social Security No. --

3 Getting to know you

You were referred to us by

Is another family member or relative a patient here? If so, who? Relationship

Your previous address

City State Zip

Emergency Contact Name

Address

City State Zip

Closest Relative not living with you

Address

City State Zip

4 Account Information

YOU

Occupation

Employer Name

Address

Phone

City

YOUR SPOUSE

Name

Occupation

Employer Name

Address

Phone

City

Check here if **YOU** are the financially responsible person for the account.

Check here if **YOUR SPOUSE** is the financially responsible person for the account.

If so, please enter their social security number in the space below.

If NOT, please enter all information below for the person responsible for the account:

Name

Social Security No.

 - -

City

State

Zip

Relationship to Patient

Phone

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 1-12% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

Welcome! So that we may provide you with the best possible care please complete both pages of this medical & dental 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

State

Zip

How often do you have dental examinations?

How often do you brush your teeth?

How often do you floss?

What other dental aids do you use? (Interplak, toothpick, etc.)

Do you have any dental problems now? Yes No If yes, please describe:

Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? If yes, where? Yes No

Do you:

Clench your teeth while Awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleeping disorders? Yes No

Smoke or chew tobacco or use other tobacco products? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neck aches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? If so, what is your biggest concern? Yes No

Have you ever had an upsetting dental experience? If yes, please describe Yes No

Is there anything else about having dental treatment that you would like us to know?

1. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? Yes No

3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines?
 Yes No If yes, please list name and dosage: _____

4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermin): Pondimen (fenfluramine); and Redux (dexfenfluramine)? Yes No

If yes to the above, did you have a medical exam for heart issues? _____

5. Are you aware of having an allergic (or adverse) reaction to any medications or substance? Yes No

If yes, please list: _____

6. Have you been a patient in the hospital during the past five years? Yes No

7. Indicate which of the following you have had, or have at present. Check "yes" or "no" to each item.

- | | | | | | |
|-------------------------------------|----------------------------------------------------|--------------------|----------------------------------------------------|--------------------------------|-------------------------------------------------------------------------|
| Heart (Surgery, Disease, Attack) | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis (mark type) | <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C |
| Chest Pain | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Problems | <input type="radio"/> Yes <input type="radio"/> No | A.I.D.S | <input type="radio"/> Yes <input type="radio"/> No |
| Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | H.I.V Positive | <input type="radio"/> Yes <input type="radio"/> No |
| High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Contact Lenses | <input type="radio"/> Yes <input type="radio"/> No | Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No |
| Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Chronic Cough | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No |
| Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No | Asthma | <input type="radio"/> Yes <input type="radio"/> No | Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Rheumatism | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Latex Sensitivity | <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |
| Swollen Ankles | <input type="radio"/> Yes <input type="radio"/> No | Allergies or Hives | <input type="radio"/> Yes <input type="radio"/> No | Neurological Disorders | <input type="radio"/> Yes <input type="radio"/> No |
| Stroke | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No |
| Diet (Special/Restricted) | <input type="radio"/> Yes <input type="radio"/> No | Radiation Therapy | <input type="radio"/> Yes <input type="radio"/> No | Fainting or Dizzy Spells | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joints (hip, knee, etc.) | <input type="radio"/> Yes <input type="radio"/> No | Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Nervous/Anxious | <input type="radio"/> Yes <input type="radio"/> No |
| Kidney Trouble | <input type="radio"/> Yes <input type="radio"/> No | Tumors | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric/Psychological Care | <input type="radio"/> Yes <input type="radio"/> No |

8. Do you use more than two pillows to sleep? Yes No

9. Have you lost or gained more than 10 pounds in the past year? Yes No

10. Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list:

11. Women: Are you pregnant or think you may be pregnant? Yes ___Months No | Nursing? Yes No

12. Women: 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 dentist of any changes in my health or medication.

Parent/Guardian Signature _____

Date _____