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Registration

Patient Information:

Title: ❑Dr. ❑Mr. ❑Mrs. ❑Ms. Name _____

Marital Status: ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Soc. Sec.# _____

Email Address _____ ❑I would like to receive correspondance via email

Patient's Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Occupation _____

Referred By _____

Person to Contact in Case of Emergency _____ Phone _____

Patient Responsibility:

Who is responsible for your accounts? ❑Self ❑Spouse ❑Parent ❑Other _____

If not yourself:

Responsible party's name _____ Date of Birth _____

Employer _____ Work Phone _____

Soc. Sec.# _____ Home Phone _____

Billing Address _____ City _____ State _____ Zip _____

Dental Benefits Information: Do you have dental benefits? ❑Yes ❑No

*Please bring your dental card to your first appointment

Name of Insured _____ Relationship to Patient _____

Subscriber's Employer _____

Insured Soc. Sec.# or ID# _____ Insured Birthdate _____

Insurance Company _____ Group # _____ Union or Local # _____

Do you have any additional dental insurance? ❑Yes ❑No If yes, complete the following:

Name of Insured _____ Relationship to Patient _____

Subscriber's Employer _____

Insured Soc. Sec.# or ID# _____ Insured Birthdate _____

Insurance Company _____ Group # _____ Union or Local # _____

PATIENT MEDICAL HISTORY

Name _____ Date _____

Date of last health care exam: _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving medical care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR PRESENTLY HAVE:

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Eating Disorders	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Sexually Transmitted Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes
Do you take aspirin daily?				No	Yes

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
Have you ever received a diagnosis of "high blood pressure"?

Are you allergic or have you had a reaction to:

a. Local anesthetics ..... No Yes
b. Penicillin or other antibiotics ..... No Yes
c. Aspirin, Ibuprofen or Tylenol ..... No Yes
d. Codeine, Valium® or other sedatives..... No Yes
e. Latex or Metals
f. Other (please specify)_____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes
Have you ever been treated for alcohol or substance abuse?	No	Yes

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____

_____

Significant findings from questionnaire or oral interview:

_____

_____

Dental management considerations:

_____

_____

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 change in my health and medication.

_____ _____ _____

Patient (Print Name) *Patient Signature* *Date*

_____ _____ _____

Doctor (Print Name) *Doctor Signature* *Date*

Patient Dental History

	YES	NO
1. Are you having discomfort at this time?	❑	❑
2. Have you ever had any serious trouble associated with previous dental treatment?	❑	❑
3. Have you ever been treated for periodontal diseases (gum disease)?	❑	❑
4. Have you ever had any orthodontic work (braces)?	❑	❑
5. Are you satisfied with the appearance of your teeth?	❑	❑
6. Do your gums bleed while brushing or flossing?	❑	❑
7. Are your teeth sensitive to hot or cold liquids?	❑	❑
8. Are your teeth sensitive to sweet liquids/foods?	❑	❑
9. Do you have any sores or lumps in or near your mouth?	❑	❑
10. Have you had any head, neck, or jaw injuries?	❑	❑
11. Do you have trouble with your bite?	❑	❑
10. Have you ever experienced any of the following problems in your jaw?		
Clicking or popping	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in chewing	❑	❑
Jaws ache in the morning	❑	❑
13. Do you clench or grind your teeth?	❑	❑
14. Do you have any unpleasant taste or mouth odor?	❑	❑
15. Do you experience burning tongue/lips?	❑	❑
16. Do you have any loose teeth?	❑	❑
17. Do you have trouble with food impaction?	❑	❑
18. Does your mouth frequently become dry?	❑	❑

19. When did you last have your teeth cleaned? _____

20. How often do you floss? _____

Authorization & Release:

I certify that I have read, understand, and answered all questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. Patients subscribe to a variety of insurance plans with different payment and reimbursement schedules. Make sure you read your plan and understand the coverage. This is your responsibility. Our office staff will assist you in every way possible and submit your dental claims. Although we try to have the insurance companies send the payment to us, sometimes it goes directly to the patient, and then it becomes your responsibility to pay the account in full.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that in the case of non-payment that I will be responsible for any and all collection fees, attorney fees, plus finance charges at the highest level rate.

_____

Signature of patient or parent if minor Date

Are you taking any medication? yes no If yes, please list on back of this form.

Medication List

(If yes to any of the following, state the drug name, dosage, and frequency)

Are you taking any of the following:

Antibiotics

Medicine for High Blood Pressure

Aspirin

Anticoagulants (blood thinners)

Cortisone (steroids)

Tranquilizers

Antihistamines

Insulin, Tolbutaide (Orinase) or similar drug for diabetes

Digitalis or drugs for heart trouble

Nitroglycerin

Herbal Supplements

Other Medications:

Doctor's Notes: