PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE			1
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE	2
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

ACCOUNT INFORMATION	4
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.	FAX NO.
YOUR SPOUSE	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.

GETTING TO KNOW YOU	3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	RELATIONSHIP:
YOU WERE REFERRED TO US BY	
YOUR FORMER ADDRESS	
CITY	STATE ZIP
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP

DENTAL HISTORY

Please check any of the following problems that apply to you.

- Sensitivity (hot, cold, sweet, pressure) ☐
  Where? UR LR UL LL
- Headaches, earaches, neck pain ☐
  - Jaw joint pain ☐
  - Teeth or fillings breaking ☐
  - Grinding or clenching teeth ☐
  - Bleeding, swollen or irritated gums ☐
  - Loose, tipped or shifting teeth ☐
  - Bad breath ☐

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

- Dentures ☐
- Partial dentures ☐
- Braces ☐
- Periodontal (gum) treatments ☐

Please share the following dates:

- Your last cleaning _____ / _____
- Your last oral cancer screening _____ / _____
- Your last complete X-Rays _____ / _____

Name of Previous Dentist _____

City _____ State _____

Phone Number _____

	Yes	No
Do you snore?	☐	☐
Has anyone reported that you choke or gasp for air while sleeping?	☐	☐
What is your neck size? (inches) _____	☐	☐
Do you wake refreshed?	☐	☐
Are you excessively tired during the day?	☐	☐
Do you smoke or use chewing tobacco?	☐	☐

How much? _____ For how long? _____

If I could change my smile, I would:

- Make them whiter ☐
- Make them straighter ☐
- Close spaces ☐
- Replace black metal fillings with tooth colored restorations ☐
- Repair chipped teeth ☐
- Replace missing teeth ☐
- Replace old crowns that don't match ☐
- Have a smile makeover ☐

ON A SCALE OF 1 – 10, WITH 10 BEING THE HIGHEST RATING:

- How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

- Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

- Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

What is the most important thing to you about your future smile and dental health? _____

MEDICAL HISTORY

Please check any of the following that apply to you:

- ☐ AIDS
- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Angina (Chest pain)
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cervical Cancer
- ☐ Chemotherapy
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Lesions (Congenital)
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ HPV (Human Papilloma Virus)
- ☐ Jaundice
- ☐ Jaw Joint Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Phen Fen (1 month +)
- ☐ Pregnant Currently
- ☐ Osteoporosis
  - ☐ Fosamax
  - ☐ Actonel
  - ☐ Reclast
  - ☐ Boniva
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other _____

Do you have any of the following drug allergies?

- ☐ Aspirin
- ☐ Codeine
- ☐ Davron
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Percodan
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Valium
- ☐ Other _____

Are you under a physician's care? What for?

_____

Are you taking any medications? What?

_____

_____

Family Physician Phone Number

_____

Patient Signature (Parent of Child) _____ Date _____

Dentist Signature _____

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.

Patient's Signature _____ Date _____ Witness _____

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