PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

1

DATE

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.

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

2 DENTAL INSURANCE

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.

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

NAME:

PERSON TO CONTACT FOR EMERGENCY

NAME:

CELL NUMBER

HOME 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. | FAX NO.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX 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.

6 Cell Phone: ☐ I consent to the dental practice using my cell phone number to (choose one or both) ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) _____

Patient's Signature_____ Date _____ Witness_____

Parent/Responsible Party's Signature _____ Relationship to Patient_____

Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides 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? _____

Have you ever used or are currently using topical fluoride? Yes No

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? ..... Yes No
If yes, where _____

Do you:

Clench or grind your teeth while awake or asleep? ..... Yes No
Bite your lips or cheeks regularly? ..... Yes No
Hold foreign objects with your teeth? (pencils, pipe, etc.) ..... 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/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
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, neckaches 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 replace your silver fillings? ..... Yes No
Would you like to keep all of your teeth all of your life? ..... Yes No

Do you feel nervous about having dental treatment? ..... Yes No
Please describe _____
Have you ever had an upsetting dental experience? ..... Yes No
Please describe _____
Have you ever been told to take a pre-medication prior to dental treatment? ..... Yes No

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

If yes, please describe _____

_____

(Please complete other side)

Patient Name	
Patient Account No.	Medical Alert

MEDICAL HISTORY

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ..... Yes ◯ No ◯
   Describe _____
2. Have you taken any medication or drugs during the past two years? ..... Yes ◯ No ◯
   If yes, please list name and dosage _____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes ◯ No ◯
   If yes, please list name and dosage _____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ..... Yes ◯ No ◯
   If yes, please list name and dosage _____
5. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... Yes ◯ No ◯
   If yes, please specify _____
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. Select "yes" or "no" to each item.

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

8. Have you lost or gained more than 10 pounds in the past year? ..... Yes ◯ No ◯
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes ◯ No ◯
   If yes, please list: _____
10. **Women:** Are you pregnant or think you could be pregnant? ◯ Yes _____ Months ◯ No **Nursing?** Yes ◯ No ◯
11. Do you use birth control prescriptions? ..... 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 _____

History Review

Dentist Signature _____ Date _____