

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

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

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

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 _____

Patient Name _____
 Patient Account No. _____

DENTAL HISTORY

Medical Alert _____

*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 _____

Address _____ State _____ Zip _____

Telephone _____

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, 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/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, 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 keep all of your teeth all of your life? Yes No
 Do you feel nervous about having dental treatment? Yes No
 If so, what is your biggest concern? _____
 Have you ever had an upsetting dental experience? Yes No
 If yes, 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 HISTORY

Medical Alert _____

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
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 prescription medications for weight loss (diet pills)? Yes No
 If yes, did you take any of the following? (circle if yes) Fen-Phen Pondimin Redux Other
 If yes to any of the above, did you have a medical exam for heart issues? Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? Yes No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No
 If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? Yes No
8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle) ...	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			
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 could be pregnant? Yes _____ Months No **Nursing?** Yes No
12. 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 _____