

PATIENT REGISTRATION

First Name _____ Last Name _____ Middle Initial _____
Patient is: Policy Holder Preferred Name _____
 Responsible Party

Patient Information

Address _____ Address 2 _____
City, State, Zip: _____ Pager _____
Home Phone _____ Work Phone _____ Ext _____ Cellular: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date _____ Age _____ Soc Sec. _____ Driver's Lic: _____
E-mail _____ I would like to receive correspondence via e-mail

Employment Status Full Time Part Time Retired Referred By _____
Student Status: Full Time Part Time Patient Phone Book
Preferred Dentist: _____ Website Family
Preferred Pharmacy: _____ Friend Other
Preferred Hygienist: _____

Responsible Party (if someone other than the patient)

First Name _____ Last Name _____ Middle Initial _____
Address _____ Address 2 _____
City, State, Zip: _____ Pager _____
Home Phone _____ Work Phone _____ Ext _____ Cellular: _____
Birth Date _____ Soc Sec. _____ Driver's Lic: _____
 Responsible Party is also a Policy Holder Primary Insurance Holder Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Insured Self Spouse Child Other
Insured Soc Sec: _____ Insured Birth Date: _____ Group # _____
Employer: _____ | Ins. Company: _____
Address: _____ | Address _____
Address 2: _____ | Address 2 _____
City, State, Zip: _____ | City, State Zip: _____
Rem. Benefits _____ .00 Rem. Deduct. _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured Self Spouse Child Other
Insured Soc Sec: _____ Insured Birth Date: _____ Group # _____
Employer: _____ | Ins. Company: _____
Address: _____ | Address _____
Address 2: _____ | Address 2 _____
City, State, Zip: _____ | City, State Zip: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No

Women: Are you:
 Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives Yes No Nursing Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain _____

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

AIDS?HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Int. Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Cold Sore/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No		

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

Comments : _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ DATE _____

Please (x) a response to indicate if you have or have had any of the following diseases or problems

	Y	N	DK		Y	N	DK
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.E. reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever taken bisphosphonates? _____

Physician(s) _____

Name

Address

City/State/Zip

Phone

Preferred Pharmacy _____

NOTICE OF PRIVACY PRACTICES

In compliance with the HIPAA (Health Insurance Portability and Accountability Act) ruling regarding patient privacy of health information, we will be able to speak with only YOU, the patient, regarding appointments and your health care. However, if you wish to designate another person to schedule appointments and be part of your dental health care, please indicate that person below and sign for verification. A copy of this indication will be kept on file with your patient chart until you indicate otherwise.

A full copy of our **Notice of Privacy Practices** is available upon request.

Designated Person

Patient Name

Signature

Date

Initial after reading _____

For Office Use Only:

We attempted to obtain writer acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign _____

Communications barriers prohibited obtaining the acknowledgement _____

An emergency situation prevented us from obtaining acknowledgement _____

Other _____

Dental Information
(Please circle answers)

Date of last dental visit _____ Reason for today's visit _____

Name of previous dentist _____

Date of last x-rays _____

Are you having dental problems or discomfort at this time? Y N

How would you describe your current dental problem? _____

Have you had a complete dental examination, including x-rays, within the past three years? Y N

How often do you see your dental hygienist? _____ When was your last hygiene visit? _____

Are you fearful of dental treatment? Slightly Moderately Extremely

Have you had difficulty with previous dental treatment? Explain _____

Have you been instructed on the correct way to brush and floss your teeth and care for your gums? Y N

Are you happy with the appearance of your teeth and smile? Y N

Do you have any problems with bad breath? Y N

Are your teeth sensitive to heat, cold or biting pressure? Y N

Do you clench or grind your teeth? Y N Day or night time?

Does food wedge between your teeth? Y N

Have you had any previous injuries to your face and jaw? Y N

Do your gums bleed when brushing? Y N

Have you ever been treated for periodontal disease? Y N

Has anyone in your family had a history of periodontal disease?

Have you ever noticed any teeth shifting or spacing? Y N

Do you have pain in or near the area of the ears? Y N

Does your jaw make a noise when opening and closing? Y N

Do you have any sores, lumps or swellings in your mouth at this time? Y N

Do any teeth feel loose? Y N

Have you ever had prolonged bleeding after a dental procedure? Y N

Is there anything about the appearance and/or function of your teeth you would like changed? _____

How do you feel about the color of your teeth? _____

How would you rate your past dental treatment? (Please circle one) Poor 1 2 3 4 5 6 7 8 9 10 Excellent

How would you rate your overall dental health? (Please circle one) Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Financial Information / Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____