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PATIENT REGISTRATION

PATIENT'S NAME ______________________________
LAST FIRST INITIAL

HOW DO YOU WISH TO BE ADDRESSED ______________________________

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

RESIDENCE: STREET ______________ STATE __________ ZIP __________

CITY ______________________________

BUSINESS ADDRESS ______________________________

TELEPHONE: RESIDENCE ______________ BUSINESS ______________

CELL ______________ APPOINTMENT CONFIRMATION NUMBER ______________

EMAIL ______________________________

PATIENT EMPLOYED BY ______________ HOW LONG HELD __________

PRESENT POSITION ______________________________

SPOUSE NAME ______________________________

SPOUSE EMPLOYED BY ______________ HOW LONG HELD __________

PRESENT POSITION ______________________________

WHO WILL PAY THIS ACCOUNT ______________________________

BILLING ADDRESS (IF DIFFERENT) ______________________________

DATE ______________ DATE OF BIRTH ______________

OTHER FAMILY MEMBERS IN THIS PRACTICE ______________________________

____

WHOM MAY WE THANK FOR THIS REFERRAL ______________________________

____

PATIENT'S SOCIAL SECURITY NUMBER ______________________________

SPOUSE'S SOCIAL SECURITY NUMBER ______________________________

SOMEONE TO NOTIFY
IN CASE OF EMERGENCY
NOT LIVING WITH YOU ______________________________

____

PAYMENT POLICY

Patients are asked to settle their accounts at the time of service. We accept Master Card, Visa, and Discover, and for more extensive treatment we are willing to extend payment plans.

Our office will complete and submit most types of dental insurance claim forms. Please remember that insurance is a method of reimbursing the patient for dental expenses. Because insurance is a contract between the patient and their employer or insurance company, the responsibility for payment of the account is your direct obligation.

CANCELLATION POLICY

If you have to reschedule or cancel an appointment, please give us at least 48 hours notice. Patients who cancel without informing us beforehand may be billed for their missed appointment and repeated cancellations may result in a patient not being rescheduled.

WE ARE COMMITTED TO PROVIDING YOU WITH QUALITY DENTAL CARE. WHAT ARE YOUR EXPECTATIONS FOR YOU AND YOUR FAMILY'S DENTAL CARE?

____

____

____

MEDICAL DENTAL HISTORY

PATIENT'S NAME ____

LAST FIRST INITIAL DATE OF BIRTH

MEDICAL HISTORY:

WHEN WAS YOUR LAST COMPLETE PHYSICAL EXAM? ____________

PHYSICIAN'S NAME ____________

ADDRESS ____________

ARE YOU UNDER A PHYSICIAN'S CARE? ____________

PLEASE LIST MEDICATIONS YOU ARE TAKING ____________

____

____

BLOOD PRESSURE:
☐ HIGH ☐ LOW ☐ NORMAL S ________ /D ________

DO YOU SMOKE? ____________

DO YOU CONSUME ALCOHOLIC BEVERAGES? ____________

\HAVE YOU TAKEN MEDICATIONS FOR WEIGHT LOSS? ____________

HAVE YOU TAKEN MEDICATIONS FOR OSTEOPOROSIS? ____________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE INDICATE WITH CHECK MARK.

- ☐ ANY HEART PROBLEMS
- ☐ CIRCULATORY PROBLEMS
- ☐ RADIATION TREATMENTS
- ☐ EXCESSIVE BLEEDING
- ☐ HIV
- ☐ ALLERGIES TO ANESTHETICS
- ☐ ALLERGIES TO LATEX
- ☐ ALLERGIES TO MEDICINES OR DRUGS ____________
- ☐ ALLERGIES TO PENICILLIN
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL JOINT
- ☐ ASTHMA
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ HEART VALVE IMPLANT
- ☐ HEPATITIS
- ☐ HERPES
- ☐ MALIGNANCIES
- ☐ MEASLES
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ ULCER

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING OPERATIONS, OR ANY OTHER MEDICAL OR DENTAL INFORMATION THAT MAY POSSIBLY AFFECT YOUR DENTAL TREATMENT.

____

____

DENTAL HISTORY:

PURPOSE OF INITIAL VISIT ____________

____

ARE YOU AWARE OF A PROBLEM? ____________

HOW LONG SINCE YOUR LAST DENTAL VISIT? ____________

WHAT WAS DONE AT THAT TIME? ____________

____

PREVIOUS DENTIST ____________

HAVE YOU MADE REGULAR VISITS? ____________

WERE DENTAL X-RAYS RECENTLY TAKEN? ____________

HAVE YOU LOST ANY TEETH? ________ WHY? ____________

WERE THERE ANY COMPLICATIONS AFTER TOOTH REMOVAL? ____________

____

HAVE THEY BEEN REPLACED? ________ WHEN? ____________

HOW? ____________

DO YOU CLENCH OR GRIND YOUR TEETH? ____________

DOES YOUR JAW CLICK OR POP? ____________

HAVE YOU EXPERIENCED ANY PAIN OR SORENESS IN THE MUSCLES OF YOUR FACE OR AROUND THE EAR? ____________

DOES FOOD GET CAUGHT BETWEEN YOUR TEETH? ____________

ARE ANY TEETH SENSITIVE TO: ☐ HOT ☐ COLD ☐ SWEETS ☐ PRESSURE

HOW OFTEN DO YOU BRUSH YOUR TEETH? ________ WHEN? ________

DO YOUR GUMS BLEED OR HURT WHEN BRUSHING? ____________

DO YOU USE DENTAL FLOSS? ________ HOW OFTEN? ________

DO YOU TAKE FLUORIDE IN ANY FORM? ____________

HAS ANYBODY TOLD YOU YOUR BREATH IS OFFENSIVE? ____________

HOW DO YOU FEEL ABOUT YOUR TEETH IN GENERAL? ____________

____

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? ____________

HAVE YOU HAD ANY UNPLEASANT DENTAL EXPERIENCES OR ANYTHING ABOUT DENTISTRY THAT YOU STRONGLY DISLIKE? ____________

____

DO YOU HAVE ANY QUESTIONS OR CONCERNS? ____________

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

____

PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF A MINOR) DATE