

PATIENT REGISTRATION AND HISTORY

Patient Information

**Please Present ID & Insurance Cards at the Front Desk.
Thank You!**

Today's Date _____

Patient Name _____
Last First Middle Initial

Preferred Name _____ SSN _____

Address _____

City _____ State _____ Zip _____

E-mail _____

Home Phone _____

Cell Phone _____

Birthdate _____ Age _____ Sex M F

Married Widowed Single Minor

Separated Divorced Partnered

Patient Employer/School _____

Occupation _____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

Whom may we thank for referring you? _____

Insurance Information

Who is responsible for this account? _____

Relation to Patient _____

Primary Insurance Co. _____

Subscriber's Name _____

Birthdate _____ SSN _____

ID# _____ Group# _____

Is patient covered by additional insurance? Yes No

Secondary Insurance Co. _____

Subscriber's Name _____

Birthdate _____ SSN _____

ID# _____ Group# _____

In Case Of Emergency, Contact:

Name _____

Relation to patient _____

Phone _____

Preferred Contact Method

Dental Reminders.....

Sending reminders and important messages to your cell phone or email will allow us to contact you without interrupting your busy day with a phone call. There are still times we will call you, but our hope is these text messages and emails will make it easier to communicate with us! Please let us know the best way to contact you:

- Cell phone
- E-mail
- Home phone
- Any of the above!

Please give us a 24 hour notice if you need to cancel or reschedule your appointment to avoid a \$50 missed appointment fee. Thank you!

Minor/Child Consent

I, being the parent or guardian of

Name of Minor/Child

do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date

Signature of Insured/Guardian

PATIENT REGISTRATION AND HISTORY CONTINUED

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever had any of the following? Please circle Y for yes or N for no:

Y N AIDS/HIV	Y N Circulatory Problems	Y N Jaw Pain	Y N Sinus Trouble
Y N Arthritis	Y N Diabetes	Y N Kidney Disease	Y N Special Diet
Y N Artificial Heart Valves	Y N Epilepsy	Y N Liver Disease	Y N Stroke
Y N Artificial Joints	Y N Headaches	Y N Low Blood Pressure	Y N Swollen Neck Glands
Y N Back Problems	Y N Heart Problems	Y N Nervous Problems	Y N Thyroid Problems
Y N Blood Disease	Y N Hepatitis Type _____	Y N Psychiatric Care	Y N Ulcer
Y N Cancer	Y N High Blood Pressure	Y N Respiratory Disease	Y N Venereal Disease
Y N Chemical Dependency	Y N Jaundice	Y N Rheumatic Fever	Y N Weight Loss, <i>unexplained</i>

Have you ever used bisphosphonate medication? Brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. yes no

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combination of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). yes no

Is there anything else we should know about your medical history? _____

DENTAL HISTORY

Please circle yes or no to indicate if you have had any of the following:

Bad breath	yes	no	Lip or cheek biting	yes	no
Bleeding gums	yes	no	Loose or broken teeth	yes	no
Blisters in mouth	yes	no	Mouth breathing	yes	no
Clicking jaw	yes	no	Orthodontic treatment	yes	no
Clenching Teeth	yes	no	Pain around ear	yes	no
Dry mouth	yes	no	Periodontal treatment	yes	no
Grinding teeth	yes	no	Sensitivity to cold	yes	no
Gums sore	yes	no	Sensitivity to heat	yes	no
Jaw pain	yes	no	Sensitivity when biting	yes	no

Reason for today's visit _____

Former Dentist _____

Date of last dental visit _____

WOMEN

Do you suspect that you are pregnant? yes no

Are you nursing? yes no

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy _____ Phone _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Shellfish
<input type="checkbox"/> Iodine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Latex	<input type="checkbox"/> Other _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date

Signature