Patient Registration

CONSENT

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that my be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. I am responsible to pay my estimated coinsurance and deductible at the time of service. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports my be obtained.

Patient Signature (Parent if Child)___________________________________Date: ________ Dentist Signature_________________________

PATIENT INFORMATION

Today's Date____

Patient's Name____
Last

____
First Middle Initial

Sex: M F Birthdate:________________________Age_______

Social Security#______________________Marital Status_______

Residence Street____________________________ Apt. #_______

City_________________________State_________Zip_________

Mailing Address____

City_____________________State_________Zip____________

Home #______________________ Work #__________________
Cell #_________________ E-Mail__________________________

HOW DID YOU HEAR ABOUT US?___________________
(i.e Dex, Yellowbook, Internet, etc. Please try to be specific.)

WHO MAY WE THANK FOR REFERRING YOU?
____

If patient is a Minor (Under 18), give parent or guardian name____

If you are 18 and older, you will be responsible for any deductibles and co-insurance amounts at the time of service, unless previous arrangements have been made with the Office Manager.

Patient's Employer/School__________________________________

Occupation____

Employer/School Address__________________________________

Spouse's Name____

Birthdate___________________ SS#________________________

Spouse's Employer____

Work #______________________Occupation________________

ACCOUNT INFORMATION

Responsible Party: Self_____ Parent______ Spouse______

Last Name____

First Name_________________________ Mdl Initial_______

Address____

City______________________State________Zip_________

Home #__________________Work#_____________________

Cell#_____________________E-Mail____________________

SS#_______________________Birthdate_________________

DENTAL INSURANCE

Insured's Name_______________________________________

Insurance Co.____

Insurance Address_____________________________________

Insured's Employer____________________________________

SS#_____________________________Birthdate____________

Group #__________________________

Secondary Insurance will need to be submitted by the patient once the Explanation of Benefits is received from your primary insurance.

EMERGENCY CONTACT

Name ____

Address ____

City_____________________________, State____________

Phone#___________________ Relationship_______________

MEDICAL AND DENTAL HEALTH HISTORY

It is important that I know about your Medical and Dental history. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Dental History

How long since you have seen a Dentist? Date:

Last Full Mouth X-rays (16-20 small films or Panoramic) – Date:

	YES	NO
Are you having problems now?	☐	☐
Please specify______________________		
Do you wear dentures? (partials or full)	☐	☐
Are you unhappy with your dentures?	☐	☐
Would you like to know more about permanent replacements?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Do your gums bleed, feel tender or irritated?	☐	☐
Are your teeth sensitive to hot, cold, sweets, pressure? (circle)	☐	☐
Are you unhappy with the appearance of your teeth?	☐	☐
Are you aware of grinding or clenching your teeth?	☐	☐
Do you have headaches, earaches, or neck pains?	☐	☐
Have you worn braces on your teeth? (orthodontics)	☐	☐
Do you have discolored teeth that bother you?	☐	☐
Would you like your smile to look better or different?	☐	☐
Do you regularly use dental floss?	☐	☐

Name of Previous Dentist:___________________________ City:______________ State:__________

How do you feel about your teeth?____

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment.

Fear of pain #___ Cost of Treatment #___ Lack of concern #___ Missing work time #___

Medical History

Do you have any current health problems?	☐	☐
Are you under a physician's care now?	☐	☐
If yes, for what?____		
What medications are you currently taking?_____________________________________		
Are you pregnant?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? Circle	☐	☐

Circle any of the following which you have had or presently have:

Heart Disease or Attack	AIDS/ARC/HIV pos.	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Hepatitis C	Asthma
Rheumatic Fever	Liver Disease	Hay Fever
Congenital Heart Lesions	Blood Transfusion	Sinus Trouble
Mitral Valve Prolapse	Drug Addiction	Allergies or Hives
Artificial Heart Valve	Hemophilia (Bleeding problems)	Diabetes
Heart Pacemaker	Fever Blisters	Thyroid Disease
Heart Surgery	Epilepsy or Seizures	Radiation Treatment
Artificial Joints (Hip, Knee)	Nervousness	Arthritis
Anemia	Psychiatric Treatment	Cortisone Medicine
Stroke	Glaucoma	Pain in Jaw Joints
Kidney Trouble	Chemotherapy (Cancer Leukemia)	Alcoholism
Ulcers	Venereal Disease	Cosmetic Surgery

Are you allergic to or have you reacted adversely to any of the following?

Aspirin	Local Anesthetic	Erythromycin	Latex (balloons, gloves, etc.)
Nitrous Oxide	Codeine	Penicillin	

Is there nay other Medical or Dental information that you feel I should know about? __________________________________

Family Physician ____ Phone #____

Patient Signature (Parent if Child) ____________________________Date: ___________Dentist Signature __________________