Patient Registration And Medical History

PATIENT INFORMATION

PATIENT'S NAME Last ________ First ________ Middle Initial ________ SEX: M F BIRTHDATE ________ AGE ______

Soc. Sec. # ________ If Patient is a Minor, give Parent's or Guardian's Name ________ TODAY'S DATE ________

Who May We Thank for Referring You to our Office? ________ Reason for this Visit ________

RESPONSIBLE PARTY INFORMATION

NAME Last ________ First ________ Middle Initial ________ MARITAL STATUS ________

RESIDENCE Street ________ Apt # ______ City ________ State ________ Zip ________

MAILING ADDRESS Street ________ Apt # ______ City ________ State ________ Zip ________

HOW LONG AT THIS ADDRESS ________ HOME PHONE ________ CELL PHONE ________

WORK PHONE ________ EMAIL ________

PREVIOUS ADDRESS (if less than 3 yrs.) Street ________ City ________ State ______ Zip ______ How Long ________

SOCIAL SECURITY # ________ BIRTHDATE ________ DRIVER'S LICENSE # ________ RELATION TO PATIENT ________

EMPLOYER ________ OCCUPATION ________ NO. YEARS EMPLOYED ________

RESPONSIBLE PARTY'S SPOUSE

NAME ________
LAST FIRST MIDDLE

EMPLOYER ________ OCCUPATION ________ (____)
NO. YEARS EMPLOYED

SOC. SEC. # ________ BIRTHDATE ________

HOME PH. ________ CELL PH. ________

WORK PH. ________ E-MAIL ________

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

NAME ________ RELATIONSHIP ________

ADDRESS ________ CITY, STATE ________

HOME PH. ________ CELL PH. ________

WORK PH. ________

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ________ Insurance Co. ________ E-MAIL ________

Insurance Co. Address ________ Insured's Employer ________

Insured's Soc. Sec. # ________ Group # ________ Local # ________

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENT?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or 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 # LACK of concern #

COST of treatment # MISSING work time #

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco?	☐	☐

PLEASE MARK YES OR NO IF YOU HAVE OR EVER HAD

	YES	NO		YES	NO
Heart Problems	☐	☐	Chronic Diarrhea	☐	☐
High Blood Pressure	☐	☐	Allergies to Anesthetics	☐	☐
Low Blood Pressure	☐	☐	General Allergies	☐	☐
Circulatory Problems	☐	☐	Blood Disease	☐	☐
Nervous Problems	☐	☐	Arthritis	☐	☐
Radiation Treatment	☐	☐	Special Diet	☐	☐
Artificial Heart Valves or Joints	☐	☐	Swollen Neck Glands	☐	☐
Recent Weight Loss	☐	☐	Rheumatic Fever	☐	☐
Back Problems	☐	☐	Sinus Problems	☐	☐
Diabetes	☐	☐	"A.I.D.S." or Other	☐	☐
Respiratory Disease	☐	☐	Immunosuppressive Disorders		
Epilepsy	☐	☐	Stroke	☐	☐
Headaches	☐	☐	Ulcer	☐	☐
Hepatitis, Jaundice or Liver Disease	☐	☐	Venereal Disease	☐	☐
Cancer	☐	☐	Chemical Dependence	☐	☐
Psychiatric Care	☐	☐	Hemophilia	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

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

Are you aware of being allergic to any other medications or substances?
If yes, list:

Is there any other Medical or Dental information that you feel we should know about?

FAMILY PHYSICIAN ________ PHONE ________ E-MAIL ________

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.

PATIENT Signature (Parent of Child) ________ Date: ________ DENTIST Signature ________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with ____

Name of Insurance Company(ies)

and assign directly to Dr. ______________________________ all benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date: ____________________ Signature ____

MINOR/ADULT CONSENT

I, being the parent or guardian of ____ do hereby request

Name of minor/child

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 ____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date: ____________________ Signature of Insured/Guardian ____

MEDICAL HISTORY UPDATE

Has there been any changes in your health since your last dental appointment? ☐ YES ☐ NO

For what conditions? ____

Are you taking any new medications? ____________ If so, what ____

Date: ____________________ Patient Signature ____

Date: ____________________ Dentist Signature ____