PATIENT REGISTRATON FORM

PLEASE PRINT/ PLEASE ANSWER ALL QUESTIONS

Date:____________

Patient Name:____
Last Name *First Name* *Initial* *Preferred Name*

Address:____ Social Security #:_____________________

City:________________________ State:_____________ Zip:____________ Home Phone:_________________________
Cell Phone:__________________________

Sex: M F Birthdate:_______________ Age:_______ Email:______________________________

Employed By:____ Occupation:_________________________
Business Address:____ Business Phone:______________________

Parent/Spouse Name:____ Birthdate:___________________________
Social Security #:_____________________

Employed By:____ Business Phone:_____________________

Who is responsible for payment on this account?______________________ Relationship to patient:________________

In case of emergency, who should be notified?________________________ Home Phone:_________________________
Cell Phone:__________________________

Whom may we thank for referring you to our office?____

Primary Insurance

Insurance Company Name:____ Group #:____________________________

Name of Subscriber:____ Subscriber #:_________________________

Additional Insurance

Insurance Company Name:____ Group #:____________________________

Name of Insured:____ Subscriber #:_________________________

**Please have the receptionist obtain a copy of your dental insurance card so we can process your claim.*

OFFICE INSURANCE POLICY

We will be happy to assist you with filing claims for predetermination and for insurance benefits; however, you must realize that we render services to the individual, not to the insurance company. You are responsible for the payment of your account. We cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim, but we will provide what assistance we can.

MEDICAL/DENTAL HISTORY

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? **Yes** **No**
Within the past year, have there been any changes in your general health? **Yes** **No**
What is the date (or approximate date) of your last physical examination?____
Are you being treated for anything now? **Yes** **No**
If yes, for what?____
What is the name of your primary care physician?____

Are you currently taking any medications, including any herbal medications? **Yes** **No**
If "Yes", please list the medication name(s), dose, frequency taken and conditions treated.

Medication	Dose	Frequency	Condition Treated

WOMEN ONLY: Are you pregnant? **Yes** **No** If "Yes", when is the due date?_________________________

Do you have, or have you had any of the following? (Check box to indicate "Yes")

- ◻ High Blood Pressure
- ◻ Heart Attack
- ◻ Stroke
- ◻ Heart Disease
- ◻ Pacemaker
- ◻ Artificial Valve
- ◻ Artificial Joint
- ◻ Osteoporosis
- ◻ Diabetes
- ◻ Rheumatic/ Scarlet Fever
- ◻ Arthritis
- ◻ AIDS or HIV Positive
- ◻ Cancer
- ◻ Hemophilia
- ◻ Chemotherapy/ Radiation Therapy
- ◻ Epilepsy
- ◻ Nervous Disorder
- ◻ Hepatitis
- ◻ Liver Disease
- ◻ Kidney Disease
- ◻ Asthma
- ◻ Tuberculosis

Are you allergic to or had any unusual reactions, such as hives, rash, shortness of breath, to any of the following drugs?

Local anesthetics ("Novocaine")…………….. ______
Penicillin……………………………………………….. ______
Tetracycline…………………………………………….. ______
Other Antibiotics…………………………………….. ______
Other Drugs…………………………………………….. ______
Barbiturates, sedatives…………………………….… ______
Aspirin……………………………………………………… ______
Codeine…………………………………………………… ______
Anti-inflammatory Meds………………………….… ______
Rubber Latex…………………………………………… ______

Are you currently taking or have you ever taken bisphosphonates, either orally or IV? (ex. Fosamax, Boniva, Actonel)
Yes **No** If "**Yes**", please specify____

Do you have any other conditions, diseases, ect, not listed above that we should be aware of?________________________
____
____

What is the reason for your dental visit today?____

When was your last visit to a dentist (if to a different office)?____

What was done at your last dental visit?____

Previous Dentist's name, address, phone number and email:____

____

____

How frequently do you brush your teeth? (circle one)

3(+) a day **Twice a day** **Once a day** **Weekly** **Seldom** **Never**

How frequently do you floss your teeth? (circle one)

1(+) a day **2 to 6 times a week** **1 to 6 times a month** **Seldom** **Never**

Please mark "**Yes**" or "**No**" to the following questions:

Yes **No** Do your gums bleed when you brush or floss?

Yes **No** Do your teeth experience sensitivity to cold, heat or chewing?

Yes **No** Are any of your teeth currently causing you pain?

Yes **No** Do you clench or grind your teeth (either consciously or during sleep)?

Yes **No** Are any of your teeth loose?

Yes **No** Are you concerned about losing your teeth?

Yes **No** Do you currently have any dental implants, dentures or partials?

Yes **No** Do you use cigarettes? How many?__________________________

Yes **No** Do you use other forms of tobacco?

Yes **No** Are you unhappy with the appearance of your teeth or smile?

If you marked "Yes" to any of the previous questions, please explain:____

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Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including diagnosis and records of treatment or examination for myself and my dependent(s) to third party insurance carriers, payers and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice and to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of Patient, Parent or Guardian (circle one):____________________________________ **Date:**_____________

Relationship to Patient:____

MEDICAL UPDATE

Date	Health Changes	Signature