

Patient Registration

If this appointment is for you, start here:

Date _____

Last name _____ First _____ MI _____

Prefers to be called by _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Email _____

Preferred method of communication:
 Home Cell Email Work

Birthdate _____

If this appointment is for your child, start here:

Date _____

Last name _____ First _____ MI _____

Prefers to be called by _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Birthdate _____

If your child's last name and/or address are not
the same as yours, fill in the top box also

Dental Insurance
Primary Carrier
Insurance Company _____
Group number _____
Employer name _____
Insured's name _____
Date of birth _____
Relationship to patient _____
Insured's Insurance ID number _____
Insured's social security number _____
Secondary Carrier
Insurance Company _____
Group number _____
Employer name _____
Insured's name _____
Date of birth _____
Relationship to patient _____
Insured's Insurance ID number _____
Insured's social security number _____

Account Information
Person Financially Responsible for Account
Name _____
Relationship to patient _____
Address _____
City _____ State _____ Zip _____
Phone _____
You
Name _____
Occupation _____
Employer's name _____
Address _____
City _____ Phone _____
Your Spouse
Name _____
Occupation _____
Employer's name _____
Address _____
City _____ Phone _____

Getting to Know You
Is another member of your family or relative a patient at our office?
Name _____
Relationship _____
You were referred to us by _____
Person to contact for emergency
Name _____
Phone _____
Relationship _____

Consent for Treatment

1. I hereby authorize Dr. Curia or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Curia to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize Dr. Curia to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
5. I understand that the filing of insurance claims is a courtesy of this office and all charges are my responsibility from the date the services are rendered. In the case of a dispute with my insurance company or undue delay of insurance payment, I agree to pay my account and accept reimbursement of insurance payment.
6. I have received and signed the HIPPA consent form.

Patient's signature _____ Date _____

Parent/Responsible Party's Signature _____

Relationship to Patient _____

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

DENTAL HISTORY

Patient Name _____

Date of last dental visit _____ last dental cleaning _____ last full mouth xrays _____

Previous Dentist's name _____ Phone _____

Address _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Waterpik, toothpick, etc) _____

Do you have any dental problems now? Yes No If yes, please describe: _____

Are any of your teeth sensitive to:

- Hot or cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No

- Have you noticed mouth odors or bad tastes? Yes No
Do you frequently get cold sores, blisters or any other oral lesions? Yes No

- Do your gums bleed or hurt? Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

Do you:

- Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or tongue regularly? Yes No
Hold foreign objects with your teeth? (pencils, nails) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Smoke or chew tobacco? Yes No

Have you ever had:

- Orthodontic treatment? Yes No
Oral surgery? Yes No
Periodontal treatment? Yes No
Your teeth ground or the bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If yes, please describe, including cause _____

Have you ever experienced:

- Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty in opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles? Yes No

- Are you satisfied with your teeth's appearance? Yes No
Would you like to keep all of your teeth all of your life? Yes No

- Do you feel nervous about having dental treatment? Yes No
If yes, what is your biggest concern? _____

- Have you ever had an upsetting dental experience? Yes No
If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete other side)

MEDICAL HISTORY

Patient Name _____

Physician's name _____ Phone _____

Address _____

Are you currently under the care of a physician? Yes No

If yes, please describe _____

Are you taking any medications, herbal remedies or vitamins? (prescriptions or OTC) Yes No

If yes, please list name and dosage _____

Are you aware of any allergic or adverse reaction to any medication or substance? Yes No

If yes, please list _____

Have you ever been told you need antibiotics or premeds before treatment? Yes No

Are you now or have you ever taken any of the following:

Fen-Phen (Fenfluramine-Phentermine) or Redux (Dexfenfluramine) Yes No

Fosamax (Alendronate) Yes No

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Abnormal bleeding	Yes No	Convulsions	Yes No	Liver disease	Yes No
AIDS/HIV positive	Yes No	Cortisone medicine	Yes No	Mitral valve prolapse	Yes No
Allergies or hives	Yes No	Diabetes	Yes No	Nervous/anxious	Yes No
Anemia	Yes No	Diet (special/restricted)	Yes No	Neurological disorders	Yes No
Arthritis/Rheumatism	Yes No	Emphysema	Yes No	Psychiatric/psychological care	Yes No
Artificial heart valve	Yes No	Epilepsy	Yes No	Radiation therapy	Yes No
Artificial joints (hip, knee, etc)	Yes No	Fainting or dizzy spells	Yes No	Rheumatic/scarlet fever	Yes No
Asthma	Yes No	Glaucoma	Yes No	Sickle cell disease	Yes No
Blood transfusion	Yes No	Handicaps/disabilities	Yes No	Sinus trouble	Yes No
Bruise easily	Yes No	Hay fever	Yes No	STD	Yes No
Cancer	Yes No	Heart attack, disease, surgery	Yes No	Stomach problems	Yes No
Chemotherapy	Yes No	Heart murmur	Yes No	Stroke	Yes No
Chest pain	Yes No	Hemophilia	Yes No	Thyroid problems	Yes No
Chronic cough	Yes No	Hepatitis	Yes No	Tuberculosis	Yes No
Cold sores/fever blisters	Yes No	Kidney trouble	Yes No	Tumors	Yes No
Congenital heart disease	Yes No	Latex sensitivity	Yes No	Ulcers	Yes No

Do you have or have you had any disease, condition or problem not listed? Yes No

If yes, please list _____

Women: Are you Pregnant? Yes ___ months No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian signature _____ Date _____

Patient Consent Form

Patient Name _____

Date of Birth _____

I understand that my medical records are confidential. I understand that by signing this consent form, I am allowing my medical information to be released for purposes of treatment, payment, or health care operations, including but not limited to, provider review functions, claims payment, and quality assessment. I also understand that I may revoke this consent by written request, at anytime, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I may refuse to consent to the use or disclosure of my personal health information, but this must be in writing. Under the Department of Health and Human Services' "Privacy Rule", Dr. Curia has the right to refuse to treat me should I refuse to disclose my personal health information.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information is required for health care operations.

When it is appropriate, the minimum necessary information will be provided to only those entities in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in my best interest.

I understand that I may be contacted by Dr. Curia by various means of communication, including but not limited to mail and e-mail.

I have read the above consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

Signature _____ Date _____