

ALFRED DELA CRUZ D.D.S

REGISTRATION FORM

(Please Print)

Welcome! Thank you for trusting us with your dental care. Our goal is to help you reach and maintain maximum oral health. In order for us to best serve you, we ask that you please complete ***all 3 pages*** of this patient registration form. All information will be kept confidential. Thank you.

PATIENT INFORMATION

Patient's Name (Last, First, MI):		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:
Patient's Social Security Number:		Driver's License Number:	State:
Home Phone:	Work Phone:	Cell Phone:	
E-mail Address (used to confirm appointments):			
Mailing Address: (Street Address/ P.O. Box)	(City)	(State)	(Zip)

Employment Information

Employer or School:			
Employer or School Address: (Street Address)	(City)	(State)	(Zip)

Emergency Contact

Name:	Phone Number:	Relationship:
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How did you hear about us?

<input type="checkbox"/> Personal Referral: Whom may we thank?	<input type="checkbox"/> ZOOM!®	<input type="checkbox"/> Invisalign®	<input type="checkbox"/> Diamond Certified
<input type="checkbox"/> Phonebook/Yellow Pages (Circle: SBC, Valley, United)	<input type="checkbox"/> PPO Insurance	<input type="checkbox"/> Other	

DENTAL INSURANCE INFORMATION

Guarantor: (person responsible for paying the bill)	Guarantor's relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other (Specify):
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PRIMARY DENTAL INSURANCE			SECONDARY DENTAL INSURANCE (if applicable)		
Name of Insured: (Last, First, Middle)		Date of Birth:	Name of Insured: (Last, First, Middle)		Date of Birth:
Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Dependent		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Dependent		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
SSN of Insured:			SSN of Insured:		
Insurance Company:	Group Number:		Insurance Company:	Group Number:	
Insurance Phone Number:	Employee ID Number:		Insurance Phone Number:	Employee ID Number:	
Insurance Mailing Address (Street Address/P.O. Box)			Insurance Mailing Address (Street Address/P.O. Box)		
City	State	Zip	City	State	Zip

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DENTAL HEALTH INFORMATION

What is the reason for your visit with us today?		Date of last visit to a dentist?	Date of last x-rays:
Name of previous dentist:		Phone number:	City/State:
Date of last visit to a dentist?	Date of last x-rays:	How many times do you floss in a week?	How many times do you brush in a day?

Has your doctor told you that you require antibiotics before receiving dental treatment?	Y	N
Are you currently in pain? If yes, please describe:	Y	N
Have you ever had a serious/difficult problem associated with any previous dental treatment? If yes, please describe:	Y	N
Do you or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?	Y	N
Do you like your smile?	Y	N

Please indicate if you have any of the following:								
Bad Breath	Y	N	Grinding Teeth	Y	N	Sensitivity to Heat	Y	N
Bleeding Gums	Y	N	Jaw Clicking or Popping	Y	N	Sensitivity to Sweets	Y	N
Loose Teeth or Broken Fillings	Y	N	Red or White Patches	Y	N	Sensitivity When Biting	Y	N
Food Collection Between the Teeth	Y	N	Sensitivity to Cold	Y	N	Sores or Growths in Your Mouth	Y	N

MEDICAL HEALTH INFORMATION

Name of primary care provider:	Phone number:	City:	May we contact your primary care provider if needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please answer the questions below. If you answer yes to any of the questions, please specify.					
Are you currently under the care of a physician? If yes, specify.	Y	N	Have you had any or do you currently have any serious medical illnesses? If yes, specify.	Y	N
Have you ever had any serious trouble associated with any previous medical, dental, or surgical treatment? If yes, specify.	Y	N	Have you been hospitalized within the past 5 years? If yes, specify.	Y	N
Have you undergone surgery or radiation therapy for a tumor, cancer, or other condition of your head and/or neck? If yes, specify.	Y	N	Are you currently taking aspirin, warfarin, other blood thinners, or other anti-inflammatory drugs? If yes, specify.	Y	N
Have you undergone any surgery/operation? If yes, specify.	Y	N	Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen"? These include combinations of Lonimin, Adipex, Fastin (brand names for phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine).	Y	N
Have you had abnormal bleeding associated with any previous surgery, extraction, or trauma? If yes, specify and how it was treated.	Y	N		Y	N
Do you bruise easily?	Y	N	Women Only: Are you pregnant/think you may be pregnant?	Y	N
Have you ever received a blood transfusion? If yes, specify the circumstances.	Y	N	Women Only: Are you currently breastfeeding?	Y	N

Do you have or have had any of the following medical conditions listed below?								
AIDS/HIV positive	Y	N	Arthritis or Other Joint Problems	Y	N	Glaucoma	Y	N
Tuberculosis	Y	N	Asthma, Emphysema, Other Lung Disease	Y	N	Fainting Spells/Seizures	Y	N
Artificial Joints	Y	N	Respiratory Problem(s)	Y	N	Sinus Problem(s)	Y	N
Blood disorders (Anemia, Hemophilia, Sickle Cell Anemia)	Y	N	Hepatitis, Jaundice, Other Liver Disease	Y	N	Allergies, Hives, Rash, or Hay Fever	Y	N
Heart Murmur	Y	N	Sexually Transmitted Disease(s)	Y	N	Diabetes	Y	N
Rheumatic Fever/Rheumatic Heart Disease	Y	N	Mental or Nervous Disorder(s)	Y	N	Kidney Disease	Y	N
Cardiovascular Disease (Heart Attack, Heart Surgery, Stroke, Angina, High Blood Pressure)	Y	N	Persistent Cough/Coughing Up Blood	Y	N	Cancer If yes, please specify:	Y	N
Other medical conditions not already specified:								

Are you allergic to or have you ever reacted adversely to (if yes to any, please specify reaction):								
Dental Anesthetics	Y	N	Tetracycline	Y	N	Erythromycin	Y	N
Latex	Y	N	Penicillin	Y	N	Codeine or Other Narcotics	Y	N
Other:								

Please list all medications you are currently taking:

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AUTHORIZATION AND RELEASE

I have completed the patient registration form and certify that this information is true and correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and that it is my responsibility to inform the office of Dr. dela Cruz of any changes in my medical status. I authorize Dr. dela Cruz and the dental staff to perform any necessary dental services that I may need during diagnosis and treatment. I also authorize Dr. dela Cruz to release any information necessary to secure the payment of insurance benefits. I understand and agree that, I am ultimately responsible for the balance of my account for any professional services rendered.*

Dental insurance policy is an agreement between the insured, the employer, and the insurance company. As a third party to this agreement, and out of courtesy for our patients, we will assist you in the preparation and submission of your dental claims. The patient/guardian is responsible for insurance claims not paid within 60 days of service.

PAYMENT IN FULL IS DUE AT THE TIME OF TREATMENT. THANK YOU.

Signature (If minor, parent or guardian signature) X	Date
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*Outstanding balances after 30 days are subject to a 1.5% monthly finance charge. Should your account be sent to collections for failure of payment, you will be responsible for any service fees incurred as a result of failure of payment for services rendered.

NOTICE OF PRIVACY PRACTICE & DENTAL MATERIALS FACT SHEET

I acknowledge that I have received a copy of the following:

- 1) Notice of Privacy Practice. This document is not a contract, authorization, release or consent form.
- 2) Dental Materials Fact Sheet, "The Facts about Fillings," (May 2004) developed by the Dental Board of California.

Signature (If minor, parent or guardian signature) X	Date
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**IF YOU ARE UNABLE TO KEEP A SCHEDULED APPOINTMENT, KINDLY GIVE US 48 HOURS NOTICE.
OTHERWISE, WE RESERVE THE RIGHT TO CHARGE FOR TIME RESERVED.**