

Ted Filandrianos D.M.D., F.A.G.D. & Associates

Cosmetic/ Implant and Restorative Dentistry

1400 Centre Street, Newton Centre

617-244-4871

PATIENT REGISTRATION

Please complete the following confidential information in full for optimum understanding of your dental wishes and desires. Everyone has individual needs, so we want to give you personal attention to assure you the most comfortable dental experience as possible.

Date
Patient Name
Address
City
Home Phone No.
Work Phone No.
Cellular Phone No.
E-mail Address
Birth date Age Male <input type="checkbox"/> Female <input type="checkbox"/>
Social Security Number
Employer
School

Responsible Party
Address
City State Zip
Responsible Party Social Security Number

DENTAL INSURANCE	
PRIMARY DENTAL CARRIER	
Insurance Co.	
Mailing Address	
Phone Number	
Subscriber DOB	
Subscriber Employer	
Subscriber Phone	
Subscriber Social Security No.	

SECONDARY DENTAL CARRIER	
Insurance Co.	
Mailing Address	
Phone Number	
Subscriber DOB	
Subscriber Employer	
Subscriber Phone Number	
Subscriber Social Security No.	

Whom may we thank for referring you:
<input type="checkbox"/> Friends Name
<input type="checkbox"/> Website/ Internet Search
<input type="checkbox"/> Other
Emergency Contact Information
Name
Relationship
Phone Number
Address
City State Zip

Would you like your payment and/or co-payment made on: <i>(If yes, please check one)</i>
<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover <input type="checkbox"/> American Express
Card No. : _____
Expiration Date: _____
Signature : _____

CONSENT FOR TREATMENT	
1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a through diagnosis of _____'s dental needs. (name of patient)	
2. Upon such diagnosis, I authorize doctor 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 entails certain risks. I understand that I can ask for a complete recital of any possible complications.	
4. Lastly, 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.	
Patient _____	Date _____
Parent of Guardian _____	

Patient Dental History

		Yes	No
1	Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>
2	Are your teeth sensitive to hot or cold liquids/ foods?	<input type="checkbox"/>	<input type="checkbox"/>
3	Are your teeth sensitive to sweet or sour liquids/ foods?	<input type="checkbox"/>	<input type="checkbox"/>
4	Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
5	Do you have any sores or bumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
6	Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>
7	Have you ever experienced any pain, clicking, etc., problems in your jaw?	<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No
8	Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
9	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
10	Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
11	Have you had any orthodontic work?	<input type="checkbox"/>	<input type="checkbox"/>
12	Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
13	Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
14	Would you like whiter teeth?	<input type="checkbox"/>	<input type="checkbox"/>
15	Would you like a cosmetic consultation?	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Physician's Name		Office Phone		Date of Last Exam	/	/
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		Yes	No
1	Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you ever been hospitalized for any surgical operation or serious illness?	<input type="checkbox"/>	<input type="checkbox"/>
3	Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>
4	Have you taken steroids in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
5	Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
6	Do you use alcohol, cocaine or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
7	Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
8	Are you taking aspirin?	<input type="checkbox"/>	<input type="checkbox"/>
9	Have you taken premedication for dental visit?	<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No
10	Are you allergic to or had a reaction(s) to:	<input type="checkbox"/>	<input type="checkbox"/>
	Local Anesthetics (e.g., novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
	Penicillin or other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
11	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
	<i>Women only:</i>		
	Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
	Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
	Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

12	Do you have or have you had any of the following?
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	Yes	No		Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement/ Implant	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/ Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/ Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/ Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/ Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>			
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than actual bill for services. I agree to be responsible for payment of all services rendered on my behalf to my dependents.

Date	/	/
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Signature	
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