Elite Dentistry Dental Registration and History

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____

Patient Name _____
Last Name First Name Middle Initial

Address _____ City _____ State _____ Zip _____

Email _____ Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ___ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (_____) _____

Spouse's Name _____ Birthdate _____

SS # _____ Spouse's Employer _____

Who may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____ Relationship to Patient _____

Insurance Co. _____ Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No Subscriber's Name _____

Birthdate _____ SS# _____ Relationship to Patient _____

Insurance Co. _____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to:
Name of insurance Company(ies)

Dr. Igal Leizerovich all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext. _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

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

Date of last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Did any previous dentists recommend dental treatment that was never performed? ☐ Yes ☐ No

If yes, what type of work was it? _____ Why was this treatment never performed? _____

Do you feel nervous about dental treatment? ☐ Yes ☐ No

Ever had an upsetting dental experience? ☐ Yes ☐ No If so, please describe _____

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? (Rotodent, Interplak, toothpick, etc.) _____

Please circle the following dental values most important to you and underline the least important:

Esthetics Comfort Longevity Function Long-term cost effectiveness

Please circle the most important feature(s) in your smile that you would like to change?

Color Shape Alignment Length Gaps Gum display Nothing, I'm happy. Other _____

Would you like your smile analyzed? ☐ Yes ☐ No If yes, is there a spouse or significant other you want to include in our discussion? ☐ Yes ☐ No

Are any of your teeth sensitive to:

- Hot or cold? ☐ Yes ☐ No
- Sweets? ☐ Yes ☐ No
- Biting or chewing? ☐ Yes ☐ No

Noticed any mouth odors or bad tastes? ☐ Yes ☐ No

Do you get cold sores, blisters or other oral lesions? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have your parents had gum disease or tooth loss? ☐ Yes ☐ No

Noticed any loose teeth or change in your bite? ☐ Yes ☐ No

Does food tend to become caught between any teeth? ☐ Yes ☐ No

If yes, where _____

Do you:

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

Have you ever had:

- Orthodontic treatment? ☐ Yes ☐ No
- Oral surgery? ☐ Yes ☐ No
- Periodontal treatment? ☐ Yes ☐ No
- Your teeth ground or bite adjusted? ☐ Yes ☐ No
- A bite plate or mouth guard? ☐ Yes ☐ No
- A serious injury to the mouth or head? ☐ Yes ☐ No

If so, please describe, including cause _____

_____

Have you 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 chewing on either side of mouth? ☐ Yes ☐ No
- Headaches, neck aches, or shoulder aches? ☐ Yes ☐ No
- Sore muscles (neck, shoulders)? ☐ Yes ☐ No

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

If yes, please describe _____

MEDICAL HISTORY

Indicate which of the following you have had, or have at present:

Tuberculosis	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hepatitis A (infectious) B (serum)	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Swollen Ankles	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	AIDS	☐ Yes ☐ No
Latex Sensitivity	☐ Yes ☐ No	Diet (Special Restricted)	☐ Yes ☐ No	HIV positive	☐ Yes ☐ No
Allergies/Hives	☐ Yes ☐ No	Artificial Joints (hip, knee)	☐ Yes ☐ No	Cold Sores/Fever Blisters	☐ Yes ☐ No
Sinus Trouble	☐ Yes ☐ No	Kidney Trouble	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No
Heart (Surgery/Disease/Attack)	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Contact Lenses	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Neurological Disorders	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Chronic Cough	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Heart Pacemaker	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No	Fainting or Dizzy Spells	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No	Nervous/Anxious	☐ Yes ☐ No
Arthritis/Rheumatism	☐ Yes ☐ No	Tumors	☐ Yes ☐ No	Psychiatric (Psychological care)	☐ Yes ☐ No

Have you been under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? _____

Physician's Name _____ Phone _____

Have you been a patient in the hospital during the past 5 years? ☐ Yes ☐ No

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

If yes, please list: _____

Have you taken any medication/drugs during the past 2 years? ☐ Yes ☐ No

List any medications you are currently taking and the correlating diagnosis: _____

_____

Are you allergic (or adverse reaction) to any medication or substance? ☐ Yes ☐ No

☐ Aspirin ☐ Local Anesthetic ☐ Barbiturates (Sleeping pills) ☐ Penicillin ☐ Codeine

☐ Sulfa ☐ Iodine ☐ Latex ☐ Other _____

WOMEN ONLY

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 need, 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 any change in my health or medication. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge will be added to any balance over 30 days in the event of default. I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient/Guardian Signature _____ Date _____