

NEW PATIENT REGISTRATION

TODAYS DATE \_\_\_\_\_

Patient's First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

I prefer to be called \_\_\_\_\_  Student  Single  Married  Widowed  Other

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security No. \_\_\_\_\_  Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Employer's address \_\_\_\_\_

Perfer to be contacted via:  CELL  TEXT  EMAIL  HOME  WORK

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

SAME AS ABOVE

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security No. \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Employer's address \_\_\_\_\_

DENTAL INSURANCE INFORMATION

NO DENTAL INSURANCE

Policy Holder Name \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_

Insured's Social Security No. \_\_\_\_\_ Insured's Relationship to Patient \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Employer's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ ID Number \_\_\_\_\_

Group Number \_\_\_\_\_ Insurance Co. phone \_\_\_\_\_

Insurance Co. address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Secondary Dental Insurance \_\_\_\_\_

OTHER INFO

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Who may we thank for referring you to our office?  Patient, if so patient's name: \_\_\_\_\_

Website  Google  Kingsport Times News  Sleep Center  Other \_\_\_\_\_

# MARTIN DENTISTRY AND THE CENTER FOR DENTAL SLEEP MEDICINE

## CONSENT AND RELEASE FORM

PATIENT NAME \_\_\_\_\_ DOB: \_\_\_\_\_

CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

PARENT NAME IF MINOR \_\_\_\_\_

### AUTHORIZATION FOR RELEASE OF ANY IDENTIFYING HEALTH/DENTAL INFORMATION

I authorize the professional office of Martin Dentistry, the doctor(s) or designated staff, the right to release any written and/or electronic information for the above patient. This includes any information regarding health/dental conditions, procedures, payments, appointment dates, and times to any authorized agencies and/or persons including insurance providers, family members, care givers, doctors, dental laboratories and/or specialists.

**Patient Signature** \_\_\_\_\_ **date** \_\_\_\_\_  
or parent of minor

### CONSENT FOR DENTAL TREATMENT AND RELATED PROCEDURES

I hereby authorize doctor(s) and/or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the above named patient to determine dental needs.

Upon such diagnosis, I authorize doctor(s) to perform all recommended treatment mutually agreed upon by me and to employ professionally trained staff, dental assistants and/or dental hygienists required to provide the proper care.

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.

I am fully aware of my responsibility to inform the doctor(s) and/or staff members of any medical conditions, medical/health changes, treatments, surgeries and/or medications taken, before every dental appointment.

**Patient Signature** \_\_\_\_\_ **date** \_\_\_\_\_  
or parent of minor

### PAYMENT POLICY AND AGREEMENT

I agree to be responsible for payment of all services rendered for above patient and/or dependents. I understand that payment is due at the time of service unless prior arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a late charge of 18% APR will be added to the balance of my account. I do understand payment options are available through a third party in which credit approval is required. As a courtesy, we file dental insurance claims but estimated percentages are to be paid on the day of service.

**Patient Signature** \_\_\_\_\_ **date** \_\_\_\_\_  
or parent of minor

### ACKNOWLEDGEMENT OF RECEIPT OF HIPPA INFORMATION

I acknowledge that I received a copy of and/or reviewed the Notice of Privacy Practices Act from Martin Dentistry.

**Patient Signature** \_\_\_\_\_ **date** \_\_\_\_\_  
or parent of minor

### MEDICAL HISTORY

**Your dental health can be related to your overall health. Conditions and medications you are taking could have an important interrelationship with the dentistry you will receive. We thank you for answering the following questions.**

What is your family doctor's name: \_\_\_\_\_ phone: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

- Are you under a physician's care now? YES NO \_\_\_\_\_
- Have you ever had a joint replacement? (ie. hip, knee, finger, other) YES NO \_\_\_\_\_
- Have you ever had a heart condition or heart surgery? YES NO \_\_\_\_\_
- Have you ever had cosmetic implants? (ie. cheek, breast, other) YES NO \_\_\_\_\_
- Have you been told that you need antibiotics before dental work? YES NO \_\_\_\_\_
  
- Have you ever been hospitalized or had any major surgery? YES NO \_\_\_\_\_
- Have you ever had a serious head or neck injury? YES NO \_\_\_\_\_
- Have you ever taken Phen-Fen or REDux for weight loss? YES NO \_\_\_\_\_
- Are you on a special diet for any reason? YES NO \_\_\_\_\_
- Do you use tobacco or controlled substances? YES NO \_\_\_\_\_

**Please list ALL medications, pills, drugs & vitamins you are taking and the reason:**

1. \_\_\_\_\_ reason \_\_\_\_\_
2. \_\_\_\_\_ reason \_\_\_\_\_
3. \_\_\_\_\_ reason \_\_\_\_\_
4. \_\_\_\_\_ reason \_\_\_\_\_
5. \_\_\_\_\_ reason \_\_\_\_\_

**Are you allergic to any of the following?**

- Aspirin    Penicillin    Codeine    Acrylic    Metal    Latex    Local Anesthetics
- Other: \_\_\_\_\_

**Women Only:** Are you: Pregnant/trying to get pregnant? YES NO   Taking Oral Contraceptives? YES NO   Nursing? YES NO

**DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING:**

AIDS/HIV Positive	<input type="radio"/> YES <input type="radio"/> NO	Cortisone Medicine	<input type="radio"/> YES <input type="radio"/> NO	Hemophilia	<input type="radio"/> YES <input type="radio"/> NO	Renal Dialysis (kidney)	<input type="radio"/> YES <input type="radio"/> NO
Alzheimer's Disease	<input type="radio"/> YES <input type="radio"/> NO	Diabetes	<input type="radio"/> YES <input type="radio"/> NO	Hepatitis A	<input type="radio"/> YES <input type="radio"/> NO	Rheumatic Fever	<input type="radio"/> YES <input type="radio"/> NO
Anaphylaxis	<input type="radio"/> YES <input type="radio"/> NO	Drug Addiction	<input type="radio"/> YES <input type="radio"/> NO	Hepatitis B or C	<input type="radio"/> YES <input type="radio"/> NO	Rheumatism	<input type="radio"/> YES <input type="radio"/> NO
Anemia	<input type="radio"/> YES <input type="radio"/> NO	Easily Winded	<input type="radio"/> YES <input type="radio"/> NO	Herpes	<input type="radio"/> YES <input type="radio"/> NO	Scarlet Fever	<input type="radio"/> YES <input type="radio"/> NO
Angina	<input type="radio"/> YES <input type="radio"/> NO	Emphysema	<input type="radio"/> YES <input type="radio"/> NO	High Blood Pressure	<input type="radio"/> YES <input type="radio"/> NO	Shingles	<input type="radio"/> YES <input type="radio"/> NO
Arthritis/Gout	<input type="radio"/> YES <input type="radio"/> NO	Epilepsy or Seizures	<input type="radio"/> YES <input type="radio"/> NO	Hives or Rash	<input type="radio"/> YES <input type="radio"/> NO	Sickle Cell Disease	<input type="radio"/> YES <input type="radio"/> NO
Artificial Heart Valve	<input type="radio"/> YES <input type="radio"/> NO	Excessive Bleeding	<input type="radio"/> YES <input type="radio"/> NO	Hypoglycemia (low)	<input type="radio"/> YES <input type="radio"/> NO	Sinus Trouble	<input type="radio"/> YES <input type="radio"/> NO
Artificial Joint	<input type="radio"/> YES <input type="radio"/> NO	Excessive Thirst	<input type="radio"/> YES <input type="radio"/> NO	Irregular Heartbeat	<input type="radio"/> YES <input type="radio"/> NO	Spina Bifida	<input type="radio"/> YES <input type="radio"/> NO
Asthma	<input type="radio"/> YES <input type="radio"/> NO	Fainting Spells/Dizzy	<input type="radio"/> YES <input type="radio"/> NO	Kidney Problems	<input type="radio"/> YES <input type="radio"/> NO	Stomach/Intest. Dis	<input type="radio"/> YES <input type="radio"/> NO
Blood Disease	<input type="radio"/> YES <input type="radio"/> NO	Frequent Cough	<input type="radio"/> YES <input type="radio"/> NO	Leukemia	<input type="radio"/> YES <input type="radio"/> NO	Stroke	<input type="radio"/> YES <input type="radio"/> NO
Blood Transfusion	<input type="radio"/> YES <input type="radio"/> NO	Frequent Diarrhea	<input type="radio"/> YES <input type="radio"/> NO	Liver Disease	<input type="radio"/> YES <input type="radio"/> NO	Swelling of Limbs	<input type="radio"/> YES <input type="radio"/> NO
Breathing Problem	<input type="radio"/> YES <input type="radio"/> NO	Frequent Headaches	<input type="radio"/> YES <input type="radio"/> NO	Low Blood Pressure	<input type="radio"/> YES <input type="radio"/> NO	Thyroid Disease	<input type="radio"/> YES <input type="radio"/> NO
Bruise Easily	<input type="radio"/> YES <input type="radio"/> NO	Genital Herpes	<input type="radio"/> YES <input type="radio"/> NO	Lung Disease	<input type="radio"/> YES <input type="radio"/> NO	Tonsillitis	<input type="radio"/> YES <input type="radio"/> NO
Cancer	<input type="radio"/> YES <input type="radio"/> NO	Glaucoma	<input type="radio"/> YES <input type="radio"/> NO	Mitral Valve Prolapse	<input type="radio"/> YES <input type="radio"/> NO	Tuberculosis	<input type="radio"/> YES <input type="radio"/> NO
Chemotherapy	<input type="radio"/> YES <input type="radio"/> NO	Hay Fever	<input type="radio"/> YES <input type="radio"/> NO	Pain in Jaw Joints	<input type="radio"/> YES <input type="radio"/> NO	Tumors or Growths	<input type="radio"/> YES <input type="radio"/> NO
Chest Pains	<input type="radio"/> YES <input type="radio"/> NO	Heart Attack/Failure	<input type="radio"/> YES <input type="radio"/> NO	Parathyroid Disease	<input type="radio"/> YES <input type="radio"/> NO	Ulcers	<input type="radio"/> YES <input type="radio"/> NO
Cold Sore/Fever Blister	<input type="radio"/> YES <input type="radio"/> NO	Heart Murmur	<input type="radio"/> YES <input type="radio"/> NO	Psychiatric Care	<input type="radio"/> YES <input type="radio"/> NO	Venereal Disease	<input type="radio"/> YES <input type="radio"/> NO
Congenital Heart Dis.	<input type="radio"/> YES <input type="radio"/> NO	Heart Pace Maker	<input type="radio"/> YES <input type="radio"/> NO	Radiation Treatments	<input type="radio"/> YES <input type="radio"/> NO	Yellow Jaundice	<input type="radio"/> YES <input type="radio"/> NO
Convulsions	<input type="radio"/> YES <input type="radio"/> NO	Heart Trouble/Disease	<input type="radio"/> YES <input type="radio"/> NO	Recent Weight Loss	<input type="radio"/> YES <input type="radio"/> NO		

Have you ever had any serious illness not listed above?  YES  NO If yes, please explain: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

- Do you snore? YES NO \_\_\_\_\_
- Have you ever been diagnosed with Sleep Apnea? YES NO \_\_\_\_\_
- Do you ever wake up gasping for air? YES NO \_\_\_\_\_
- Have you ever been told that you stop breathing during sleep? YES NO \_\_\_\_\_
- Have you ever had an overnight sleep study?(if yes, when & where) YES NO \_\_\_\_\_
- Do you, or have you ever used a CPAP? YES NO \_\_\_\_\_
- Would you like info about alternative CPAP possibilities? YES NO \_\_\_\_\_

Signature of Patient, Parent, or Guardian \_\_\_\_\_ date \_\_\_\_\_

PATIENT NAME

BIRTHDATE

**DENTAL HISTORY**

What is the main reason for your visit today? \_\_\_\_\_

Do you have any dental problems or concerns? YES NO If yes, please describe: \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_

Last X-rays: Full Mouth/pan \_\_\_\_\_ bwx \_\_\_\_\_ other \_\_\_\_\_

May we contact your previous dentist to receive copies of current x-rays & records? YES NO

Previous Dentist \_\_\_\_\_ Phone \_\_\_\_\_

How often do you have dental cleanings and examinations? 3 mo. 4 mo. 6 mo. Other \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss your teeth? \_\_\_\_\_

Do you use other dental aids to help clean your teeth? \_\_\_\_\_

**Are your teeth sensitive to:**

Hot or cold? YES NO

Sweets? YES NO

Biting or Chewing YES NO

If yes, please comment: \_\_\_\_\_

**Have you ever had:**

Head/mouth/neck injury YES NO

Oral surgery? YES NO

Periodontal (gum) disease YES NO

comments

Have you ever had braces or orthodontic treatment? YES NO \_\_\_\_\_

If yes, are you pleased with the results? YES NO \_\_\_\_\_

Would you like information about Invisalign@? YES NO \_\_\_\_\_

Do you ever get mouth sores, blisters or lesions? YES NO \_\_\_\_\_

Do your gums ever bleed or hurt? YES NO \_\_\_\_\_

Have you ever had periodontal (gum) therapy? YES NO \_\_\_\_\_

Have you noticed any bad tastes or odors? YES NO \_\_\_\_\_

Have you noticed any loose teeth or bite changes? YES NO \_\_\_\_\_

Do you bite your lips or cheeks regularly? YES NO \_\_\_\_\_

Do you use tobacco or smokeless tobacco? YES NO \_\_\_\_\_

Do you clinch or grind your teeth? YES NO \_\_\_\_\_

Have you experienced clicking/popping of the jaw? YES NO \_\_\_\_\_

Have you ever worn a night guard or mouth piece? YES NO \_\_\_\_\_

Do you have difficulty opening your mouth? YES NO \_\_\_\_\_

Do you have tired jaws, especially in the morning? YES NO \_\_\_\_\_

Do you have regular headaches or neck aches? YES NO \_\_\_\_\_

Are you satisfied with the appearance of your teeth? YES NO \_\_\_\_\_

Do you like the color or shade of your teeth? YES NO \_\_\_\_\_

Is there anything you would like to change? YES NO \_\_\_\_\_

Do you feel nervous about having dental treatment? YES NO \_\_\_\_\_

Is there anything we can do to help that fear? YES NO \_\_\_\_\_

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

If yes, please describe \_\_\_\_\_