

Patient Registration Form

Welcome to Sunset Dental Professionals.

Our goal is to assist you in achieving optimal and complete dental health. Please take a moment to enter or update your information. All of your information is confidential and secure.

Thank You For Choosing Us!

HOW DID YOU HEAR ABOUT US? Our practice grows by referrals from our dental family. Who may we thank for referring you to our practice? _____ Today's Date: _____

----- Personal Information -----

Patient's Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: () _____ - _____ Home Phone #: () _____ - _____ SS#: _____ - _____ - _____

Driver's License #: _____ E-mail: _____

Employer: _____ Occupation: _____ Work Phone: () _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Parent (if minor) or Spouse: _____ Birth Date: ____ - ____ - ____ SS# _____ - _____ - _____

Employer: _____ Occupation: _____ Work Phone: () _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

If full time student, name & address of school: _____

----- Dental Information -----

Please answer each question. Check Yes or No:

- Are any of your teeth sensitive to: Hot Cold Sweets Chewing
- Do you know of any inflamed area, growths, sore spots, unhealed injuries in or around your mouth? Yes No
- Have you noticed any loosening of your teeth? Yes No
- Does food tend to become caught between your teeth? Yes No
- Do you suffer from pain and / or swelling of your gums? Yes No
- Do your gums often bleed when you brush or floss your teeth? Yes No
- Have you ever had any unfavorable reaction from local anesthetic? (Lidocaine etc.) Yes No
- Are you missing teeth? Yes No
If yes, have they been replaced? Yes No
- Do you ever have bad breath or taste in your mouth? Yes No
- Do you wear any removable appliances? Yes No
- Do you participate in any recreational contact sports activities? Yes No
- Are you satisfied with the appearance of your smile? Yes No

Habits

- Do You:**
- Hold foreign objects with your teeth (such as pencils, pipe, nails, fingernails)? Yes No
 - Bite your lips or cheeks regularly? Yes No
 - Clench or grind your teeth while awake or asleep? Yes No
 - Mouth breathe while awake or asleep? Yes No

Problems of the Jaw

- Have you experienced or currently have:**
- Clicking or popping of the Jaw? Yes No
 - TMJ Pain? Yes No
 - Difficulty in opening or closing? Yes No
 - Difficulty in chewing? Yes No
 - Do you suffer from headaches..... Yes No.How often per week? 1, 2, 3, 4, 5+

Past History of Dental Treatment

- Have you ever had:**
- Orthodontic treatment? Yes No
 - Oral Surgery or extractions? Yes No
 - Periodontal surgery treatment? Yes No

PATIENT HEALTH HISTORY QUESTIONNAIRE

Please check any of the following that you have ever had or been treated for:

- Yes No Abnormal bleeding / Bruise easily
- Yes No AIDS
- Yes No Alcohol / Drug Abuse
- Yes No Anemia
- Yes No High cholesterol
- Yes No Asthma, hay fever or sinus trouble
- Yes No Blood Thinners (Coumadin, Warfarin, Plavix)
- Yes No Cancer Date: _____
- Yes No Chemotherapy / Radiation treatment
- Yes No Congenital heart defect
- Yes No Diabetes: Type I or Type II
- Yes No Difficulty in breathing
- Yes No Epilepsy, fainting or seizures
- Yes No Glaucoma
- Yes No Headache Problems
- Yes No Heart attack Date: _____
- Yes No Heart murmur
- Yes No Heart surgery Date: _____
- Yes No Hepatitis
- Yes No High Blood Pressure
- Yes No HIV Positive
- Yes No Joint replacement Date: _____
- Yes No Kidney disease or malfunction
- Yes No Liver disease
- Yes No Latex allergies
- Yes No Pacemaker
- Yes No Phen-Fen, have you ever taken Phen-Fen?
- Yes No Prosthetic valve, mitral valve prolapse
- Yes No Psychologic or psychiatric care
- Yes No Rheumatic fever / Scarlet fever
- Yes No Rheumatism or arthritis
- Yes No Sickle cell disease / Traits
- Yes No Stroke Date: _____
- Yes No Taking Osteoporosis Meds: Boniva, Fosamax, Actonel
- Yes No Tuberculosis
- Yes No Thyroid disease or malfunction / problems
- Yes No Ulcers
- Yes No Women: are you pregnant? Months: _____
- Yes No Women: have you reached menopause?

General Health: Excellent Good Fair Poor

Name of physician: _____

Phone: (____)____-____ City: _____

Are you under medical care now? Yes No

Date of last complete physical Examination? Mo: _____ Yr: _____

Are you taking any medication? Yes No

Please List: _____

Are you taking any recreational drugs (Marijuana, etc.)

Yes No

Are you sensitive or allergic to any medicine? Yes No

Penicillin Tetracycline Sulfa Drugs Aspirin

Codiene Other _____

Have you ever had a serious illness or accident that required hospitalization? (What and When?) _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: ____-____-20____

Person to contact in case of emergency.

Name: _____

Relationship: _____

Cell #: (____)____-____

Do you have any disease, condition or problem not listed above? _____

Financial Agreement And Consent To Treat

Initial Below:

- ____ I hereby authorize any insurance payment directly to the Dental Office, otherwise payable to me.
- ____ **\$25 LATE FEE** Any account balance over 30 days will incur a late fee of \$25. In case of default of payment I promise to pay any legal interest on the balance due, together with collection costs and any reasonable attorney fees incurred to effect collection on this account.
- ____ I hereby authorize the Dentist and Staff to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care, or in case of a medical emergency. The information on this page and the medical history are correct to the best of my knowledge.
- ____ **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT COMPLETED, REGARDLESS OF INSURANCE COVERAGE.**

Signature: _____ Date: ____-____-20____

Print Name: _____

Adult Patient Father Mother Guardian Other: _____

Doctor Signature: _____ Date: ____-____-20____

Pre-Med: Yes No