*** How did you hear about our office? ______________________________ ***

PATIENT REGISTRATION

ID: ____ Chart ID: ____

First Name: ____ Last Name: ____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: ____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ____ Last Name: ____ Middle Initial: ____

Address: ____ Address 2: ____

City, State, Zip: ____ Pager: ____

Home Phone: ____ Work Phone: ____ Ext: ____ Cellular: ____

Birth Date: ____ Soc Sec: ____ Drivers Lic: ____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ____ Address 2: ____

City: ____ State / Zip: ____ Pager: ____

Home Phone: ____ Work Phone: ____ Ext: ____ Cellular: ____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ____ Age: ____ Soc. Sec: ____ Drivers Lic: ____

E-mail: ____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ____ Pref. Dentist: ____

Employer ID: ____ Pref. Pharmacy: ____

Carrier ID: ____ Pref. Hyg.: ____

Section 3

Other Phone: ____

Primary Insurance Information

Name of Insured: ____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ____ Insured Birth Date: ____

Employer: ____ Ins. Company: ____

Address: ____ Address: ____

Address 2: ____ Address 2: ____

City,State,Zip: ____ City,State,Zip: ____

Rem. Benefits: ____.00 Rem. Deduct: ____.00

Secondary Insurance Information

Name of Insured: ____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ____ Insured Birth Date: ____

Employer: ____ Ins. Company: ____

Address: ____ Address: ____

Address 2: ____ Address 2: ____

City,State,Zip: ____ City,State,Zip: ____

Rem. Benefits: ____.00 Rem. Deduct: ____.00

MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________
Are you on a special diet? ◯ Yes ◯ No ______________________
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ______________________

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______________________

Comments: ______________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ______________

Patient Dental History

Patient Name: ____

Name of Previous Dentist and Location ________________________________

Date of Last Exam____________________

	Yes	No
1. Do you gums bleed while brushing or flossing?	____	____
2. Are your teeth sensitive to hot or cold liquids/food?	____	____
3. Are your teeth sensitive to sweet or sour liquids/food?	____	____
4. Do you feel pain on any of your teeth?	____	____
5. Do you have any sores or lumps in or near your mouth?	____	____
6. Have you had any head, neck, or jaw injuries?	____	____
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	____	____
Pain (joint, ear, side of face)	____	____
Difficulty in opening or closing	____	____
Difficulty in chewing	____	____
8. Do you have frequent headaches?	____	____
9. Do you clench or grind your teeth?	____	____
10. Do you bite your lips or cheeks frequently?	____	____
11. Have you ever had difficulty during tooth extractions in the past?	____	____
12. Do you wear partial or full dentures?	____	____
If yes, date of placement_________________		
13. Have you ever had Orthodontic treatment (Braces)?	____	____
14. Have you ever received oral hygiene instruction regarding the care of you teeth and gums?	____	____
15. Have you had periodontal treatment (deep cleaning)?	____	____
16. Date of last x-rays ____________________		

Cosmetic Questionnaire

With the recent advancements in materials and techniques, many of our patients are asking more questions about cosmetic dental procedures. In order to better serve you, please take a moment and let us know how you feel about the appearance of your smile.

Name____Date__________________

	Yes or No	
Do you like the appearance of your teeth?	❑	❑
Are your teeth as straight as you would like them to be?	❑	❑
Do you think you have a "gummy" smile?	❑	❑
Are you happy with the length, width, and shape of your teeth?	❑	❑
Do you have any chipped teeth?	❑	❑
Do you have any missing teeth?	❑	❑
Do you have any spaces between your teeth?	❑	❑
Do you have any discoloration, stains or spots on your teeth?	❑	❑
Would you like for your teeth to be whiter?	❑	❑
Do you have any dental work that you don't like?	❑	❑
Do you have any silver fillings that you would like changed to white?	❑	❑
Has anyone you've known had any cosmetic dentistry done that interests you?	❑	❑

If there was anything else you could change about the appearance of your teeth, what would it be?

____
____
____
____
____
____

FINANCIAL POLICY

Thank you for selecting us as your dental care provider. We are committed to the highest level of quality, preventive treatment. Please understand that payment for services rendered are part of your treatment. Outlined below is our financial policy. Please read it carefully and sign it before being seen by the doctor.

- Full payment is due at time of service for non-insurance patients.
- We accept cash, checks, Visa/MasterCard, American Express and Discover.
- If you have dental insurance, you are expected to pay our estimated portion, all co-pays, or deductibles at the time of service.
- We offer a no interest or extended payment plan (Care Credit) upon approved credit.
- We reserve the right to charge $50 (per scheduled hour) for appointments that are missed or cancelled without a 48-hour notice.
- A fee of $25 will be charged for all returned checks.

______ (Initials)

Our practice is committed to providing the best treatment for our patients, based on a diagnosis of what is needed to save and prevent further loss or damage to your gums or teeth. We charge fees that are usual and customary for our area. Our diagnosis will not be based on what your insurance company will cover, the amount of money you have left towards your maximum, or how economical the treatment will be. Again, it will be based on what is in the best interest of your dental and health care. Regardless of any insurance company's arbitrary determination of what is usual and customary, you are responsible for payment.

We will accept assignment of insurance benefits. You will be expected to pay your estimated portion of the fee for treatment. **Be aware that this is only an estimate.** The actual amount could vary depending on what your insurance will cover or unexpected changes of treatment. You are ultimately responsible for any balance for services rendered. We cannot bill your insurance company unless you give us your insurance information. This information must be provided before treatment begins. Your insurance policy is a contract between your employer and your insurance company. We are not a party to that agreement. Until your insurance company has paid their portion of services rendered, the unpaid balance will show on your monthly statement.

______ (Initials)

I have read, understand and agree to the above terms.

Print Patient Name

____ Date ____________________

Signature ____
(patient, parent, or guardian)