

**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**

Additional Comments:

**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?  Nursing?  
 Taking oral contraceptives?

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?  
 AIDS/HIV Positive  Chest Pains  Frequent Headaches  Irregular Heartbeat  Scarlet Fever  
 Alzheimer's Disease  Cold Sores/Fever Blisters  Genital Herpes  Kidney Problems  Shingles  
 Anaphylaxis  Congenital Heart Disorder  Glaucoma  Leukemia  Sickle Cell Disease  
 Anemia  Convulsions  Hay Fever  Liver Disease  Sinus Trouble  
 Angina  Cortisone Medicine  Heart Attack/Failure  Low Blood Pressure  Spina Bifida  
 Arthritis/Gout  Diabetes  Heart Murmur  Lung Disease  Stomach/Intestinal Disease  
 Artificial Heart Valve  Drug Addiction  Heart Pace Maker  Mitral Valve Prolapse  Stroke  
 Artificial Joint  Easily Winded  Heart Trouble/Disease  Pain in Jaw Joints  Swelling of Limbs  
 Asthma  Emphysema  Hemophilia  Parathyroid Disease  Thyroid Disease  
 Blood Disease  Epilepsy or Seizures  Hepatitis A  Psychiatric Care  Tonsillitis  
 Blood Transfusion  Excessive Bleeding  Hepatitis B or C  Radiation Treatments  Tuberculosis  
 Breathing Problem  Excessive Thirst  Herpes  Recent Weight Loss  Tumors or Growths  
 Bruise Easily  Fainting Spells/Dizziness  High Blood Pressure  Renal Dialysis  Ulcers  
 Cancer  Frequent Cough  Hives or Rash  Rheumatic Fever  Venereal Disease  
 Chemotherapy  Frequent Diarrhea  Hypoglycemia  Rheumatism  Yellow Jaundice

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 \_\_\_\_\_

## EXAMINATION QUESTIONNAIRE

### General Information

Date \_\_\_\_\_ Patient's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Home Telephone \_\_\_\_\_ First \_\_\_\_\_ Last \_\_\_\_\_ Nickname \_\_\_\_\_ School \_\_\_\_\_ YRS. MOS. \_\_\_\_\_  
 Musical Instrument played \_\_\_\_\_ Sports/Hobbies \_\_\_\_\_ Referred by \_\_\_\_\_ Grade \_\_\_\_\_  
 Name of Parents or Guardian \_\_\_\_\_  
 Home Mailing Address \_\_\_\_\_  
 Name of person responsible for account \_\_\_\_\_  
 Father's Occupation \_\_\_\_\_ Employed by \_\_\_\_\_ Business Telephone \_\_\_\_\_  
 Business Address \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Employed by \_\_\_\_\_ Business Telephone \_\_\_\_\_  
 Business Address \_\_\_\_\_  
 Brother's Ages \_\_\_\_\_ Sister's Ages \_\_\_\_\_  
 Patient's Dentist \_\_\_\_\_ City \_\_\_\_\_ Pediatrician/Physician \_\_\_\_\_  
 Dental Insurance  Yes  No Name & Address of Ins. Company \_\_\_\_\_  
 Insured's Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

### Medical History

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Is patient presently under a physician's care? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Is patient taking any pills, drugs, medication? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever had an unusual reaction to medications? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Is patient allergic to anything? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Was patient absent more than five days last year due to illness?
<input type="checkbox"/>	<input type="checkbox"/>	Has patient had any major surgery? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Does patient have any chronic problem with <input type="checkbox"/> kidney <input type="checkbox"/> heart <input type="checkbox"/> lung <input type="checkbox"/> liver <input type="checkbox"/> other? _____
<input type="checkbox"/>	<input type="checkbox"/>	Are there any other medical problems not mentioned above? _____
<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever been diagnosed or treated for any of the following:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diabetes <input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Emotional <input type="checkbox"/> Tonsils removed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Anemia <input type="checkbox"/> Heart trouble <input type="checkbox"/> Endocrine <input type="checkbox"/> Adnoids removed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Asthma <input type="checkbox"/> Fainting <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Bone <input type="checkbox"/> Prolonged bleeding

### Dental History

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever sucked thumb or fingers?	<input type="checkbox"/>	<input type="checkbox"/>	Has a dentist ever placed a retainer or space maintainer?
<input type="checkbox"/>	<input type="checkbox"/>	Does patient breathe predominantly through the mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Does patient resemble mother/father? Who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does patient have any speech problems?	<input type="checkbox"/>	<input type="checkbox"/>	Is patient adopted? Age adopted _____
<input type="checkbox"/>	<input type="checkbox"/>	Does patient clench or grind teeth (at night)?	<input type="checkbox"/>	<input type="checkbox"/>	Does anyone in family have similar dental conditions? Who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Any noticeable difficulty in chewing or swallowing food?	<input type="checkbox"/>	<input type="checkbox"/>	Has any member of the family had orthodontic treatment? Who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does patient have pain or clicking upon opening or closing mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Has patient had any previous orthodontic treatment?
<input type="checkbox"/>	<input type="checkbox"/>	Has patient had any severe head or face injuries?	<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever been teased about appearance of his/her teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Have any teeth been injured or chipped due to accidents?	<input type="checkbox"/>	<input type="checkbox"/>	Are you aware some appointments are during school time?
<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever had any abscessed teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Does patient see dentist regularly?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been informed of any extra teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Last appointment - Mo. _____ Yr. _____
<input type="checkbox"/>	<input type="checkbox"/>	Have any teeth (baby or permanent) been removed by extraction?	<input type="checkbox"/>	<input type="checkbox"/>	Does patient brush teeth regularly? _____ times/day.

In your words, what is the problem? \_\_\_\_\_

Today's appointment is for a preliminary examination. The purpose of this examination is to determine whether or not an orthodontic problem exists at this time or will exist in the future, and the approximate nature of this problem. If correction of the problem is indicated, treatment might begin as soon as possible or in the future depending upon the specific problem involved.

**PROFESSIONAL SERVICES ARE RENDERED AND CHARGED TO YOU, NOT THE INSURANCE COMPANY.**

Please understand that the contract is between you and the insurance company and payment for services is your responsibility.

We will file a claim to your insurance company. All deductibles and fee amounts not covered by insurance are due at the time of treatment unless written financial arrangements are made with the financial staff PRIOR to starting treatment. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. You will receive a statement every month your account shows a balance due, regardless of insurance expectations. If at the end of 60 days, your insurance company has not paid; you are responsible for the entire balance. Upon request, we will supply you with a copy of the claim, so you can resubmit, if necessary. Failure to pay will result in the account being turned over to a collection agency for non-payment, which will include any fees incurred for such actions.

**EXTENDED PAYMENT PLANS**

We offer a third party organization providing loans to patients for dental treatment. A patient must qualify for this type of arrangement. Applications are available in our office.

**BROKEN APPOINTMENT POLICY**

Please consider your scheduled appointments carefully. We ask for a 24-hour notice of cancellation. Your appointment is reserved just for you. If you miss this appointment it takes away from another patient to receive dental care. After two missed appointments, without calling or canceling, you may be asked to pursue treatment on a non-scheduled time, as available. If you have three missed appointments, without calling or canceling, we will be happy to forward your records to the dentist of your choice.

**TREATMENT FEES**

All treatment fees are honored for 90 days from the day that the fee was quoted. In unforeseen cases additional treatment may be diagnosed from the original treatment fee. If you have any questions regarding your account please do not hesitate to ask. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signed

Date