



Patient ID:

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## Patient Information

Patient Name: \_\_\_\_\_  
Last First M.I. How do you wish to be addressed?

Address: \_\_\_\_\_  
Street address City State Zip

Home ☎ Cell ☎ Work ☎ Do you wish to receive appointment reminders via text? Yes  No

Email: \_\_\_\_\_ Marital Status: Single  Married  Divorced  Widowed

How did you hear about our office? \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F Social security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Driver's license #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Years held: \_\_\_\_\_

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

Emergency contact name/relationship/☎: \_\_\_\_\_

## Primary Dental Insurance

Subscriber's name: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Subscriber's Soc. Sec. #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Subscriber's date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address (if different from patient): \_\_\_\_\_

Subscriber's employer: \_\_\_\_\_

Employer's Address (if different): \_\_\_\_\_

Employer's ☎: \_\_\_\_\_

Plan name: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Ins. Co. ☎ \_\_\_\_\_

## Secondary Dental Insurance

Subscriber's name: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Subscriber's Soc. Sec. #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Subscriber's date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address (if different from patient): \_\_\_\_\_

Subscriber's employer: \_\_\_\_\_

Employer's Address (if different): \_\_\_\_\_

Employer's ☎: \_\_\_\_\_

Plan name: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Ins. Co. ☎ \_\_\_\_\_

### Authorizations:

I authorize my insurance companies to pay the dentist all insurance benefits otherwise payable to me for any services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits on my behalf. I understand that as the patient or responsible party I am financially responsible for all charges whether or not paid by my insurance. All dental emergencies, or any dental services performed without prior financial arrangements, must be paid for at the time of service.

I understand that the office reserves the right to charge me \$50/hr. for all failed appointments for which I do not give at least 48 hrs. notice of canceling or rescheduling.

I consent to all dental services deemed necessary by my treating dentist and assigned employees. This includes but is not limited to: Radiographs and dental anesthetics. I have informed my dental providers of all current and past health concerns that may affect my dental treatment and/or health.

Signature

Date

Relationship to patient

# REGISTRATION



Patient ID:

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## Dental History

Purpose of today's visit: \_\_\_\_\_

Last dentist's name/city: \_\_\_\_\_ Last visit: \_\_\_\_\_ Last cleaning: \_\_\_\_\_

Reason for changing dentist: \_\_\_\_\_

Have you ever had a bad dental experience: \_\_\_\_\_

Are you nervous about seeing the dentist? Yes  No  If yes, please tell us why: \_\_\_\_\_

How often do you brush: \_\_\_\_\_ Do you floss? Yes  No  How often? \_\_\_\_\_

- |        |  |        |   |
|--------|--|--------|---|
| Yes No | Does your jaw click or pops                | Yes No | Do you have problems eating             |
| Yes No | Do you have headaches, jaw pain, neck pain | Yes No | Have you ever had braces/orthodontics   |
| Yes No | Do you clench or grind your teeth          | Yes No | Have you ever had facial or jaw trauma  |
| Yes No | Do you have a dry mouth                    | Yes No | Have you ever had facial or jaw surgery |
| Yes No | Do your gums bleed                         | Yes No | Are you happy with your smile           |
| Yes No | Do you have tender or swollen gums         | Yes No | Do you want whiter teeth                |
| Yes No | Have you been told you have gum disease    | Yes No | Do you have mouth pain                  |

## Medical History

- |        |                              |        |                              |  |                                  |
|--------|------------------------------|--------|------------------------------|--|----------------------------------|
| Yes No | Heart disease                | Yes No | Hepatitis Type _____         | Yes No                                 | Hearing loss                     |
| Yes No | Stroke                       | Yes No | Diabetes                     | Yes No                                 | Fainting spells                  |
| Yes No | Congenital heart defect      | Yes No | Infectious Mononucleosis     | Yes No                                 | Glaucoma                         |
| Yes No | Rheumatic fever              | Yes No | Herpes                       | Yes No                                 | Have you taken Fen-fen or Redux  |
| Yes No | Abnormal blood pressure      | Yes No | Arthritis                    | Yes No                                 | Have you taken Fosamax           |
| Yes No | Anemia                       | Yes No | Sexually transmitted disease | Yes No                                 | Depression                       |
| Yes No | Bleeding disorder            | Yes No | Kidney disease               | Yes No                                 | Mental disorder _____            |
| Yes No | Tuberculosis or lung disease | Yes No | Tumor or malignancy          | Yes No                                 | Panic/anxiety attacks            |
| Yes No | Asthma/Hay Fever             | Yes No | Cancer _____                 | Yes No                                 | Emotional/Nervous disorder       |
| Yes No | Joint replacement            | Yes No | Chemotherapy                 | Yes No                                 | History of tobacco use           |
| Yes No | Sinus Condition              | Yes No | Radiation Therapy            | ☞Type _____ Pack/day _____ years _____ |                                  |
| Yes No | Epilepsy/seizures            | Yes No | History of drug addiction    | Women:                                 |                                  |
| Yes No | Ulcers                       | Yes No | Alcoholism                   | Yes No                                 | Are you pregnant? Due date _____ |
| Yes No | Liver disease                | Yes No | AIDS or HIV+                 | Yes No                                 | Are you nursing                  |
| Yes No | Jaundice                     | Yes No | Immune Suppressive Disorder  | Yes No                                 | Do you use hormone contraception |

Other condition: \_\_\_\_\_

Are you under a physician's care Yes  No  \_\_\_\_\_

Physician's name/location/☎: \_\_\_\_\_

Do you have any allergies: Yes  No  Please list: \_\_\_\_\_

Please all medications you are taking: \_\_\_\_\_

Doctor's note only:

Signature

Date

Relationship to patient