PATIENT REGISTRATION

PATIENT

Name: Last _____ First _____ Middle Init. _____

Preferred Name _____ Sex: M F Marital Status _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Ext _____ Cell _____

E-Mail _____ Soc. Sec. #_____ - _____ -_____ Employer _____

Emergency Contact _____ Relationship _____ Phone _____

HOW DID YOU HEAR ABOUT OUR OFFICE? Phone Book Newspaper Internet Google Yelp Yahoo

Other _____ May we thank another patient for referring you? _____

RESPONSIBLE PARTY ☐ Same as above

Relationship to Patient (Circle One): Self Spouse Parent Other _____

Name: Last _____ First _____ Middle Init. _____

Preferred _____ Sex: M F Marital Status _____ Birthdate _____ Age _____

Soc. Sec. # _____ - _____ -_____ Drivers License _____

Mail Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Ext _____ Cell _____

E-Mail _____ Employer _____

DENTAL INSURANCE ☐ On File

Employer or Group Name _____
Insurance Co. _____
Group No. _____
Insured's Name _____
Insured's Birthdate _____
Insured's ID _____

2nd DENTAL INSURANCE

Employer or Group Name _____
Insurance Co. _____
Group No. _____
Insured's Name _____
Insured's Birthdate _____
Insured's ID _____

CONSENT (Please read carefully and sign below)

- The above information is true to the best of my knowledge.
- I authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.
- I understand that the doctors are Premier Providers for Delta Dental and NOT Preferred Providers nor contracted with any insurance company, and I am ultimately responsible for all dental fees. Co-payments and deductibles are only estimated, and we cannot guarantee how much, if anything, your insurance will pay. These fees are due and payable at the time services are rendered. I also assign all insurance benefits to the doctor. Any payments received by the doctor from my insurance will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.
- I authorize automated appointment reminder calls, texts, and emails to be sent to me unless I opt out.
- I acknowledge that I have received the Dental Materials Fact Sheet and the Notice of Privacy Practices (on waiting room table).
- I acknowledge that I am subject to a $50 charge for any appointment cancelled without 24 hours notice.

Patient, or if minor, Parent or Legal Guardian Signature _____ Date _____

HEALTH HISTORY

DENTAL HISTORY

Last Dental Visit Date _____ Last Full Mouth Xrays Date _____

Name of Previous Dentist _____ City _____ State _____

Are you having any problems now? Y N What? _____

Rate your present dental health (circle): Poor Fair Good Excellent

	Yes	No
Do you regularly use dental floss?	☐	☐
Do your gums bleed or feel tender or irritated?	☐	☐
Have you had Periodontal (gum) treatment?	☐	☐
Do you wear Partials or Dentures?	☐	☐
Are your teeth sensitive to Hot, Cold, Sweets or Pressure?	☐	☐
Do you Grind or Clench your teeth?	☐	☐
Do you have headaches, earaches, or neck pains?	☐	☐
Have you worn braces on your teeth? Year _____	☐	☐
Are you unhappy with the appearance of your teeth?	☐	☐
Would you like your smile to look better or different?	☐	☐
Are you apprehensive about dental treatment?	☐	☐

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment (1, 2, 3, 4):

_____ FEAR of pain

_____ COST of treatment

_____ LACK of concern

_____ MISSING work time

MEDICAL HISTORY

	Yes	No	If Yes, Explain:
Do you have any current health problems?	☐	☐	_____
Are you under a physician's care now?	☐	☐	_____
What medications are you currently taking?	☐	☐	_____
Do you smoke or chew tobacco?	☐	☐	_____
Have you ever taken bisphosphonates?	☐	☐	_____
Are you Pregnant?	☐	☐	Due Date: _____

PLEASE √ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV+	☐	☐	Cancer	☐	☐	Hepatitis	☐	☐	Shingles	☐	☐
Anaphylaxis	☐	☐	Chemotherapy	☐	☐	High blood pressure	☐	☐	Shortness of breath	☐	☐
Anemia	☐	☐	Cough (persistent)	☐	☐	Jaw pain	☐	☐	Skin rash	☐	☐
Arthritis (Rheumatism)	☐	☐	Diabetes	☐	☐	Kidney disease	☐	☐	Stroke	☐	☐
Artificial heart valves	☐	☐	Epilepsy	☐	☐	Liver disease	☐	☐	Surgical implant	☐	☐
Artificial joints	☐	☐	Fainting	☐	☐	Mitral valve prolapse	☐	☐	Swelling of feet/ankles	☐	☐
Asthma	☐	☐	Food allergies	☐	☐	Nervous problems	☐	☐	Thyroid disease	☐	☐
Atopic (allergy prone)	☐	☐	Glaucoma	☐	☐	Pacemaker	☐	☐	Tobacco habit	☐	☐
Back problems	☐	☐	Headaches	☐	☐	Psychiatric care	☐	☐	Tonsillitis	☐	☐
Blood disease	☐	☐	Heart murmur	☐	☐	Rapid weight change	☐	☐	Tuberculosis	☐	☐
Circulatory Problem	☐	☐	Heart problems	☐	☐	Radiation treatment	☐	☐	Ulcer/colitis	☐	☐
Chemical dependency	☐	☐	Heart surgery	☐	☐	Respiratory disease	☐	☐	Venereal disease	☐	☐
Cortisone treatment	☐	☐	Hemophilia	☐	☐	Rheumatic fever	☐	☐	Material allergies	☐	☐
Complication after surgery	☐	☐	Herpes	☐	☐	Scarlet Fever	☐	☐	(latex/chemicals/metal…)		

If you answered YES to any of the questions listed above, please explain: _____

_____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING (circle):

Aspirin Local Anesthetic Erythromycin Nitrous Oxide Codeine Penicillin Latex

Other (please list) _____

Physician _____ Phone _____

Patient/Parent/Legal Guardian Signature _____ Date _____

Dentist Signature _____ Date _____