Mitchell Dentistry Patient Registration

Patient's Name: ____**Birthdate:** ______/_______/_______ **Soc. Sec. No:** ___________________

Address: ____**City:** ______________________ **State:** ________ **Zip:**_______________

Home Phone: _______________________ **Mobile:** _________________________ **Work:** _____________________ **Ext:** ______________

Email Address (for appointment reminders): ____

Is it ok to send you Text Message Reminders on your mobile phone ☐ Yes ☐ No

Employment Information

Employer Name: ____ **Occupation:** ______________________________

Address: ____ **Phone:** ____________________________

Health Information

Please check those that apply:

☐ Heart Disease
☐ Irregular Heart Beat
☐ Angina Pectoris
☐ Heart Pacemaker
☐ Heart Surgery
☐ High Blood Pressure
☐ Rheumatic Fever
☐ Heart Murmur
☐ Prosthetic Heart Valve
☐ Mitral Valve Prolapse
☐ Artificial Joints:
Hip / Knee / Other

☐ Thyroid disease
☐ Epilepsy
☐ Arthritis
☐ Tumor History
☐ Chemotherapy
☐ Radiation
☐ Night Sweats
☐ Diabetes
☐ Anemia
☐ Liver Disease
☐ Stroke
☐ Autoimmune disease
☐ COPD

☐ Hepatitis
☐ Jaundice
☐ Venereal Disease
☐ AIDS/HIV
☐ Asthma
☐ Ulcers
☐ Sinus Trouble
☐ Glaucoma
☐ Lung Disease
☐ Tuberculosis
☐ Emphysema
☐ Herpes Type I
☐ Herpes Type II

☐ Pregnant
☐ Birth Control Pills
☐ Latex Allergy
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Sleep Apnea

OTHER:
☐ ________________
☐ ________________
☐ ________________

- Have you been admitted to a hospital or needed emergency care in the last 12 months? ☐ Yes ☐ No
  If yes, please explain: ____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician(s): ____
- Do you have any present dental complaints? ☐ Yes ☐ No Where in your mouth? __________________________________
- Do you have any pain in or near your ears? ☐ Yes ☐ No
- Pain in your jaw? ☐ Yes ☐ No
- Do you clench your teeth day or night? ☐ Yes ☐ No
- Have you been told you snore? ☐ Yes ☐ No
- Have you ever been diagnosed with Sleep Apnea? ☐ Yes ☐ No If yes, how long ago? _______________________________
- Have you ever had local anesthetics (Novocaine, Xylocaine, Carbocaine)? ☐ Yes ☐ No
  Have you had any adverse reaction to it? ☐ Yes ☐ No
- Are you taking any medication, pills, or drugs? ☐ Yes ☐ No If yes, please list: ___________________________

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Dental History

When was your last Panorex or full-mouth x-rays taken? _______________ What office? _________________________

Approximate date of your last dental hygiene appointment? ________________

Approximate date of last dental visit: ___________________ For? _______________________________

Dental Insurance Information

Name of Subscriber/Primary Insured: ____
First Name Last Name

Subscriber's Birth Date: ________________________ **Subscriber Soc. Sec. No:** ________________________________

Insurance Company: ___________________________________ **Insurance Phone:** _______________________________

Subscriber Soc. Sec. No: ____________________________ **Insurance ID:** ____

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** ____

Secondary Dental Insurance:

****Please Note, We Do NOT File Secondary Insurance. An Attending Doctor Statement Will Be Issued So That You Can File Your Secondary Insurance. Your Secondary Insurance Will Reimburse You Directly.**

Referral Information

Whom may we thank for referring you to our practice? ☐ **Relative** ☐ **Friend** ☐ **Co-worker** ☐ **Neighbor** ☐ **Another patient**

Name of person or office referring you to our practice: ____

OR ☐ **Online** ☐ **Newspaper** ☐ **Dental Office** ☐ **Other:** ____________________________________

Consent for Services

I agree to assume full financial responsibility for all treatment rendered. I, the undersigned, do hereby fully authorize to examine, treat, and care for me as decided or deemed necessary. I realize and accept the risks involved.

____ **Date:** _______/_________/_______

Signature of patient, parent, or guardian