

MEDICATIONS

Please list any medications you are taking, including prescription, over the counter, or herbal medications and/or supplements:

Medication: _____ Amount: _____ Reason for taking: _____
Medication: _____ Amount: _____ Reason for taking: _____
Medication: _____ Amount: _____ Reason for taking: _____

MEDICAL HISTORY

Physician's Name: _____ Date of last visit: _____ Reason for visit: _____
Are you required by your physician to take premedication before dental treatment? Yes No If yes, what medication? _____
Do you currently take any bisphosphate medications for osteoporosis or cancer treatment (Fosamax, Actonel, Zometa, Aredia, Boniva, etc)?
If so, which medication? _____

Do you have, or have you had, any of the following? (Check all that apply)

<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Blood pressure problem	<input type="checkbox"/> Anemia	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Abnormal Bleeding/Blood Disease	<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Frequent Heartburn/GERD	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Kidney or Bladder problems	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> History of chemical dependency	<input type="checkbox"/> Stroke(s)
<input type="checkbox"/> Hepatitis, Jaundice, or Liver trouble	<input type="checkbox"/> Bulimia or Anorexia	<input type="checkbox"/> Fainting spells or seizures	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Depression, or Anxiety	<input type="checkbox"/> Thirst or Dry mouth	<input type="checkbox"/> Oral Herpes	

Cancer/Tumor If so, were you treated with any of the following: Surgery Radiation Chemotherapy

Please explain fully any "checked" answers on medical history:

ALLERGIES

Are you allergic, or have you reacted adversely, to any of the following?

<input type="checkbox"/> Local anesthetics	<input type="checkbox"/> Aspirin, Acetaminophen or Ibuprofen	<input type="checkbox"/> Penicillin or other antibiotics	
<input type="checkbox"/> Codeine, Demerol, other narcotics	<input type="checkbox"/> Reaction to metals	<input type="checkbox"/> Fluoride	
<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Latex or rubber dam	<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Other _____

Women: (Check all that apply)

Are you taking contraceptives or hormones Are you nursing? Are you pregnant or do you think you might be pregnant?

DENTAL HEALTH HISTORY

What is the reason for your visit today? _____ Date of last dental visit: _____ Date of last dental x-rays: _____

Is there anything we can do or need to know about you to make your experience in our office more comfortable? _____

Please check all that you would answer "Yes" to:

<input type="checkbox"/> Are you apprehensive about dental treatment?	<input type="checkbox"/> Have you ever had a TMJ problem?
<input type="checkbox"/> Have you had problems with previous dental care?	<input type="checkbox"/> Do you clench or grind your teeth frequently?
<input type="checkbox"/> Have you used nitrous oxide? (Laughing gas)	<input type="checkbox"/> Do you get frequent or severe headaches?
<input type="checkbox"/> Have you had problems getting numb?	<input type="checkbox"/> Have you had a blow to the jaw (trauma)?
<input type="checkbox"/> Do you have cold sores?	<input type="checkbox"/> Do your gums bleed when you brush/floss?
<input type="checkbox"/> Are your teeth sensitive to hot, cold, or sweets?	<input type="checkbox"/> Does food get caught between teeth?

I hereby acknowledge that a copy of this office's NOTICE OF PRIVACY PRACTICES has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

SIGNATURE _____

DATE _____

PATIENT REGISTRATION

PATIENT
First Name Last Name Middle Initial
Address Street Apt City State Zip
Gender: Male Female Soc. Sec. # Date of Birth
Work Phone Cell Phone Home Phone
Email Preferred method of contact (please check one) Work # Cell # Home # Email Text Msg
Patient's Employer Occupation
Who referred you to our office? Marital Status (please check) Single Married Separated Divorced Widowed

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

Name Employer Occupation
Mailing Address Home Phone
City, State, Zip Work/Cell Phone
Relationship to patient: Spouse Child Dependent

INSURANCE INFORMATION

ADDITIONAL INSURANCE

Do you have Dental Insurance? Yes No
If you checked Yes, please answer the following questions:
Subscriber's Name (Name of Insurance Policy Holder)
Subscriber's Birthdate Subscriber ID#
Insurance Company
Ins. Co. Address
City, State, Zip
Group Name
Group #
Subscriber's Employer
Patient's relationship to subscriber: Self Spouse Child

Do you have additional Dental Insurance? Yes No
If you checked Yes, please answer the following questions:
Subscriber's Name (Name of Insurance Policy Holder)
Subscriber's Birthdate Subscriber ID#
Insurance Company
Ins. Co. Address
City, State, Zip
Group Name
Group #
Subscriber's Employer
Patient's relationship to subscriber: Self Spouse Child

FEES AND PAYMENTS

Initial

We make every effort to keep the cost of your care to a minimum. You can help by paying upon completion of each visit. Other arrangements can be made with our Office Manager depending on the circumstances. A cost estimate of any procedure you need will be provided upon request. If you have dental insurance we will be glad to submit your claims. Please remember that insurance is considered a method of reimbursing the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible or deductible amount, co-insurance or any other balance not paid by your insurance company.

In regard to late arrival or cancellation of your appointment, please give us 48 hours notice if you are unable to make it to your appointment. If adequate notice is not given, a \$45 charge will be applied to your account for each hour of time missed.

I have read the above conditions and agree to their content. The Signature on file is my authorization of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

SIGNATURE

DATE