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

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

ADDITIONAL INSURANCE

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

PATIENT_____ Date of Birth_____
First Name Last Name

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, Actonal, Zometa, Aredia, Boniva, etc)?
If so, which medication? _____

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

___Heart Problem
___Artificial Heart Valve
___Abnormal Bleeding/Blood Disease
___Ulcers
___Kidney or Bladder problems
___Hepatitis, Jaundice, or Liver trouble
___Depression, or Anxiety
___Heart Murmur
___Blood pressure problem
___Seasonal Allergies
___Arthritis
___Joint Replacement
___Bulimia or Anorexia
___Thirst or Dry mouth
___HIV/AIDS
___Anemia
___Sinus Problems
___Frequent Heartburn/GERD
___History of chemical dependency
___Fainting spells or seizures
___Oral Herpes
___Pacemaker
___Easy Bruising
___Asthma
___Diabetes
___Stroke(s)
___Epilepsy

___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?

___Local anesthetics
___Codeine, Demerol, other narcotics
___Nitrous Oxide
___Aspirin, Acetaminophen or Ibuprofen
___Reaction to metals
___Latex or rubber dam
___Penicillin or other antibiotics
___Fluoride
___Sulfa drugs
___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:

___Are you apprehensive about dental treatment?
___Have you had problems with previous dental care?
___Have you used nitrous oxide? (Laughing gas)
___Have you had problems getting numb?
___Do you have cold sores?
___Are your teeth sensitive to hot, cold, or sweets?
___Have you ever had a TMJ problem?
___Do you clench or grind your teeth frequently?
___Do you get frequent or severe headaches?
___Have you had a blow to the jaw (trauma)?
___Do your gums bleed when you brush/floss?
___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