Patient Registration Form

Name_____**I prefer to be called**_____ **Birth date**_____ **Age**_____ **M / F**

Address _____**Apt**_____**City**_____**State**_____ **Zip** _____

Home phone_____ **Cell phone**_____ **Work phone**_____

I consent to the dental practice using my cell phone number to (choose one or both) ___call or ___text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. _____Initial

Email_____ **Best way to reach me between 8 am and 5 pm** _____

If college student, F.T./P.T., Name of School_____**City**_____**State**_____

If minor, parent's name(s)_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____ **Phone** _____

Previous dentist_____ **City**_____**Phone** _____**Date of last visit**_____

What are your main reasons for seeking dental treatment today?_____

_____

RESPONSIBLE PARTY

Name of person responsible for this account_____ **Relationship to patient**_____

Address_____**Apt**_____**City**_____**State**_____**Zip**_____

Home phone_____ **Cell phone**_____ **Work phone**_____

Employer _____

INSURANCE INFORMATION

PRIMARY:

Ins. Co_____

Address _____

Subscriber:_____

ID #_____**Birth date**_____

Policy#_____ **Group #**_____

SECONDARY:

Ins. Co. _____

Address _____

Subscriber:_____

ID#_____**Birth date**_____

Policy#_____**Group #**_____

RELEASE AND CONSENT

I understand that I am responsible for the total cost of my dental care, and I agree to pay for any portion not covered by dental insurance. I understand that payment is due at time of service unless other arrangements have been made. Returned checks are subject to a service charge of $25. If I have insurance, I hereby authorize my insurance benefits to be paid directly to the dentist. I also authorize the dentist to release any information required for payment to be made. I authorize release of information concerning my health and treatment to other dentists or physicians. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Patient Signature _____ **Date** _____
(Parent or guardian if patient is a minor)

DENTAL HEALTH HISTORY

Have you ever been treated for any of the following? (Please circle all that apply)

Endodontic (root canals) **Orthodontics (teeth straightened)** **Oral Surgery (teeth removed)**
Periodontics (treatment for gum disease) **Prosthodontics (dentures)** **TMJ (Problems of the jaw joint or muscles)**
Dental Implants

How do you feel about going to the dentist? Please circle one below:

Relaxed and confident **A bit uneasy** **Very anxious or upset** **Other**_____

Do you wish information about any of the following extended services? We might not otherwise ask. Please circle all that apply.

Cosmetic dentistry **Treatment for snoring** **Treatment for bad breath**

Medical Health History

Please circle the appropriate answer for each question. Leave blank if you do not understand the question.

Yes No Are you under a physician's care now?
If yes _____

Yes No Have you ever had a serious head or neck injury?
If yes _____

Yes No Have you been hospitalized or had a major operation?
If yes _____

Yes No Are you on a special diet? If yes _____

Yes No Do you have a personal physician?
Name _____Phone ( )_____Kaiser #_____

Please indicate history of the following conditions (*mark each with the appropriate response, Y-yes , N-no*)

Y N	AIDS/HIV Positive	Y N	Cortisone Medicine	Y N	Hemophilia	Y N	Radiation Treatments
Y N	Alzheimer's Disease	Y N	Diabetes	Y N	Hepatitis A	Y N	Recent Weight Loss
Y N	Anaphylaxis	Y N	Drug Addiction	Y N	Hepatitis B or C	Y N	Renal Dialysis
Y N	Anemia	Y N	Easily Winded	Y N	Herpes	Y N	Rheumatic Fever
Y N	Angina	Y N	Emphysema	Y N	High Blood Pressure	Y N	Rheumatism
Y N	Arthritis/Gout	Y N	Epilepsy or Seizures	Y N	High Cholesterol	Y N	Scarlet Fever
Y N	Artificial Heart Valve	Y N	Excessive Bleeding	Y N	Hives or Rash	Y N	Shingles
Y N	Artificial Joint	Y N	Excessive Thirst	Y N	Hypoglycemia	Y N	Sickle Cell Disease
Y N	Asthma	Y N	Fainting Spells/Dizziness	Y N	Irregular Heart Beat	Y N	Sinus Trouble
Y N	Blood Disease	Y N	Frequent Cough	Y N	Kidney Problems	Y N	Spina Bifida
Y N	Blood Transfusion	Y N	Frequent Diarrhea	Y N	Leukemia	Y N	Stomach/Intestinal Disease
Y N	Breathing Problems	Y N	Frequent Headaches	Y N	Liver Disease	Y N	Stroke
Y N	Bruise Easily	Y N	Genital Herpes	Y N	Low Blood Pressure	Y N	Swelling of Limbs
Y N	Cancer	Y N	Glaucoma	Y N	Lung Disease	Y N	Thyroid Disease
Y N	Chemotherapy	Y N	Hay Fever	Y N	Mitral Valve Prolapse	Y N	Tonsillitis
Y N	Chest Pains	Y N	Heart Attack/Failure	Y N	Osteoporosis	Y N	Tuberculosis
Y N	Cold Sores/Fever Blisters	Y N	Heart Murmur	Y N	Pain in Jaw Joints	Y N	Tumors or Growths
Y N	Congenital Heart Disorder	Y N	Heart Pacemaker	Y N	Parathyroid Disease	Y N	Ulcers
Y N	Convulsions	Y N	Heart Trouble/ Disease	Y N	Psychiatric Care	Y N	Venereal Disease
						Y N	Yellow Jaundice

Y N Do you have any other condition not noted above? Please describe_____

Y N Have you ever taken Fen Phen, Redux? Y N Have you ever taken Fosamax, Actonel, Boniva, Zometa, Reclast?

Y N Are you currently using any prescription or over-the-counter medications? Please list:_____
_____
_____

Do you use: Cigarettes, pipes, cigars Y N Smokeless tobacco Y N Alcohol Y N Recreational drugs Y N

Women: Are you, or could you be pregnant? Y N Are you nursing? Y N

Are you allergic to any of the following, Penicillin, Aspirin, Codeine, Sulfa drugs, other Antibiotics, Foods, Latex, Metals, Local Anesthestics? If yes, please list_____

Emergency contact:_____Relationship_____Phone_____

I understand that the information I have provided is complete and correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status.

Patient signature (or parent if minor)_____ Date_____

Dentist signature_____ Date_____