Registration and History

1 Patient Information

Date: _____

Patient Name (Last, First, MI): _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: _____ Age: _____ Birthdate: _____ SS# _____

Married Widowed Single Divorced

Occupation: _____ Patient Employer/School: _____

Employer/School Address: _____

Spouse's Name: _____ Birthdate: _____

Spouse's Employer: _____

Whom may we thank for referring you/How did you hear about us?

_____

2 Dental Insurance

Who is responsible for this account? _____ Relationship to Patient: _____

Insurance Company: _____ Group # _____

Is patient covered by additional insurance? _____

Subscriber's Name _____ Birthdate: _____ SS# _____

Relationship to Patient: _____

Insurance Company: _____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please Print the Name of Patient, Parent, Guardian, or Personal Representative

_____ _____

Date Relationship to Patient

3 Contact Info

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

E-Mail: _____

Opt in for Text Reminders (Y/N): _____

Emergency Contact: _____ Relationship: _____

Home Phone: (_____)_____ Cell: (_____)_____

4 Dental History

Former Dentist:_____

City/State: _____

Date of last visit: _____

Check if you've had the following:

- ☐ Any Tobacco Use
- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Clicking/Popping Jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pains or tiredness
- ☐ Lip or Cheek Biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth Breathing
- ☐ Mouth Pain, Brushing
- ☐ Orthodontic Treatment
- ☐ Pain around ear
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Sores or growths in mouth
- ☐ Snoring

How often do you floss?

_____

How often do you brush?

_____

Have you had complications following dental treatment? If yes, explain: _____

_____

5 Health History

Physicians Name: _____ Date of Last Visit: _____

Are you now taking or have you ever taken any weight loss drugs? Y/N _____

Please check if you've experienced the following:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type: _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Special Diet
- ☐ Stroke
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained

5 Health History (continued/women only)

Are you pregnant? (Y/N) _____ Due Date: _____ Are you nursing? (Y/N) _____

Taking Birth Control Pills? (Y/N) _____

6 Medications

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

_____

Pharmacy Name: _____

Phone: (_____)_____

7 Allergies

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Metals: _____
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: _____

_____

8 Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursements from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial agreements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content. I also acknowledge that I have received the notice of privacy practices.

_____ Date: _____ Relationship: _____

Signature of Patient, parent or guardian.

_____ Date: _____ Relationship: _____

Signature of guarantor of payment/responsible party.