

PATIENT REGISTRATION

PATIENTS NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 OCCUPATION _____
 EMPLOYER _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 SINGLE MARRIED DIVORCED WIDOWED
 REFERRED BY: _____
 FULL TIME STUDENT PARTIME STUDENT SCHOOL _____

DATE OF BIRTH _____ AGE _____
 SOCIAL SECURITY# _____-_____-_____
 HOME PHONE () _____-_____
 WORK PHONE () _____-_____
 INSURANCE PLAN _____
 POLICY/GROUP # _____
 DRIVERS LICENSE # _____
 CELL PHONE (_____) - _____
 E-MAIL _____
 MAY WE CALL YOU AT WORK yes no _____

PATIENTS SPOUSE (or PARENT if patient is a minor)

NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 OCCUPATION _____
 EMPLOYER _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____
 SOCIAL SECURITY # _____
 WORK PHONE () _____
 INSURANCE PLAN _____
 POLICY/GROUP# _____
 DRIVERS LICENSE # _____
 CELL PHONE (_____) - _____

FAMILY MEMBER NOT LIVING WITH PATIENT

NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 HOME PHONE () _____ RELATIONSHIP _____
 WORK PHONE (_____) - _____

PERSON TO CALL IN CASE OF AN EMERGENCY

NAME _____
 RELATIONSHIP _____
 PHONE () _____
 WORK PHONE () _____

APPOINTMENTS:

A minimum charge will be made for a failed or cancelled appointment without prior notification of at least 24 hrs. This fee covers only a portion of the overhead such as salaries, utilities, etc. which still have to be paid whether you are present or not. Once an appointment is made please remember this time has been reserved for you.

TREATMENT CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk .

FINANCIAL RESPONSIBILITY:

I understand the responsibility of payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, regardless of any insurance coverage, unless financial arrangements have been made. I further understand that a finance and/ or billing charge will be added to any overdue balances (minimum \$5.00 per month or 1.5%). I hereby assign all insurance benefit payments to the Doctor.

INSURANCE/DENTAL PLAN BENEFITS

I have read my plan benefits, exclusions and limitations and I take responsibility for understanding such.

PATIENTS SIGNATURE _____ DATE _____

Medical History

MEDICAL DOCTOR'S NAME _____ PHONE _____ DATE OF LAST PHYSICAL EXAM _____

ARE YOU CURRENTLY IN GOOD HEALTH? _____

DO YOU HAVE OR EVER HAD THE FOLLOWING: Yes or No

- | | | |
|--|---|---|
| Y/N | Y/N | Y/N |
| <input type="checkbox"/> Allergies to Drugs, if yes what | <input type="checkbox"/> Excessive Bleeding From Cuts | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Herpes (oral or genital) |
| <input type="checkbox"/> Heart Ailments | <input type="checkbox"/> Blood Transfusions dates _____ | <input type="checkbox"/> ARC (Aids related complex) |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Alcohol or Chemical Dependency |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Artificial Implant | |
| <input type="checkbox"/> Congenital Heart Defects | <input type="checkbox"/> Thyroid | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | (Females only) |
| <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Liver Problems | Are you pregnant? yes, what month _____ <input type="checkbox"/> no _____ |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis | Childbirth Yes No |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Normal |
| <input type="checkbox"/> Psychiatric Care/Emotional Problems | <input type="checkbox"/> Ulcer or Colitis | <input type="checkbox"/> C-Cection |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Hayfever or Allergies | <input type="checkbox"/> Complications |
| <input type="checkbox"/> Malignancies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Are you taking or have ever taken Phen -Fen | <input type="checkbox"/> Eye Disorders | |
| | <input type="checkbox"/> Tonsillitis | |

Have you ever been hospitalized? _____ Have you ever had any surgeries? If so list dates _____

Are you presently under the care of a physician? _____ if so, for what? _____

Are you taking any medication now? if so please describe _____

DENTAL HISTORY

Reason for this visit? _____ Is this an emergency? _____ When did it start _____ Dr's Initials <>

Is there anything that relieves the pain? _____ Makes it worse _____

Date of last Dental exam _____ Was any treatment performed? if so, what _____ Date of last x-rays _____

Have you had a bad experience at the Dentist? _____ If so, describe _____

Have you had any major dental treatment? Describe _____

How often do you visit the Dentist? 6 months yearly rarely only when it hurts

Name of previous Dentist _____ Why did you leave? _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: yes or no

- | | |
|--|--|
| Y/N | Y/N |
| <input type="checkbox"/> Injury to Face or Jaws | <input type="checkbox"/> Bleeding or complications from extractions |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Headaches or Tenderness in Jaw Joint |
| <input type="checkbox"/> Food Impaction | <input type="checkbox"/> Clenching or Grinding Day Night |
| <input type="checkbox"/> Burning sensation of the tongue | <input type="checkbox"/> Pain or noise in ears or Jaw Joint |
| <input type="checkbox"/> Periodontal (gum) surgery Treatment | <input type="checkbox"/> Orthodontics (braces) |
| <input type="checkbox"/> Frequent cold sores or blisters | <input type="checkbox"/> Swelling or lumps in or around the mouth |
| <input type="checkbox"/> Teeth Sensitive to heat, cold, pressure, sweets | <input type="checkbox"/> Oral habits (fingernail biting, cheek biting etc) |
| <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Cigarette, Pipe, or Cigar Smoking | <input type="checkbox"/> Tobacco Chewing |
| <input type="checkbox"/> Unpleasant taste | |
| <input type="checkbox"/> Fluoride supplements | |
| <input type="checkbox"/> Do you use dental floss? | Texture of toothbrush (Hard) (Medium) (Soft) |
| <input type="checkbox"/> Other oral hygiene aids | Frequency of Brushing (Times per day) _____ |

Describe any unusual dental events or experiences you have had? _____

Patient or Guardian SIGNATURE _____ Date _____

Reviewed by _____ date _____ (Dr. init) _____ date _____ (Dr. init) _____ date _____ (Dr. init) _____

MED HX UPDATE _____ () MED HX UPDATE _____ () MED HX UPDATE _____ ()

MED HX UPDATE _____ () MED HX UPDATE _____ () MED HX UPDATE _____ ()