DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

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Home Phone ( )_____ Cell Phone ( )_____ E-mail _____

PATIENT INFORMATION

Name _____ Age_____ SS/HIC/Pat. ID # _____
Last Name First Name Middle Initial

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F Birthdate _____ ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Minor

Patient Employer/School _____ Occupation _____ Employer/School Phone ( )_____

Employer/School Address_____ Whom may we thank for referring you? _____

In case of emergency, who should be notified?_____ Phone ( )_____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec # _____ Phone ( )_____

Address (If different from Patient's)_____ City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Ph. ( )_____

Insurance Co. _____ Insurance Ph. ( )_____

Contract # _____ Group # _____ Subscriber # _____ Sub #_____ Branch # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____ Phone ( )_____

Address (If different from Patient's)_____ City _____ State _____ Zip _____

Subscriber Employed by _____ Soc. Sec. #_____ Business Ph.( )_____

Insurance Co. _____ Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

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

The above-named doctor 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.

Signature of Patient, Parent, Guardian or Personal Representative	Print Name	Relationship to Patient	Date

OFFICE FINANCIAL AND ATTENDANCE POLICIES

1. Payment is expected at the time of treatment unless arrangements have been made in advance.
2. Failure to keep the account current may result in one or all of the following:
   a. Termination of services
   b. A late charge of 1.5% of the account balance per month
   c. A credit bureau report filing
3. The office requests 24 hour advance notification for appointments that cannot be kept in order to avoid issuing a missed appointment charge.
4. A pattern of missed appointments or last minute cancellations may result in a termination of services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained because of:

_____ Individual refused to sign _____ Communication barriers _____ An Emergency situation ____ Acknowledgment not returned by parent

HIPAA information given. Medical and Dental History reviewed verbally with Patient named above: Initial_____Date: ._____

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____ Phone (____) _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken filings
- ☐ Gum health
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Do you require antibiotics before dental appointment? ☐ Yes ☐ No Reason _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectivety referred to as " fen-phen?" These include combinations of Ionimin, Adipex. Fastin (brand names of phentermine), Pondimin (fenflurarmine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you ever taken Fosomax, etc? ☐ Yes ☐ No

Have you had a serious Illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had problems with any of the following:

- ☐ Anemia
- ☐ Arthritis. Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shorthess of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

_____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex _____
- ☐ Other _____

_____

SIGNATURE

The submitted information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ _____

Date