

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



DATE				<b>1</b>
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		FAX		
CELL		EMAIL		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				

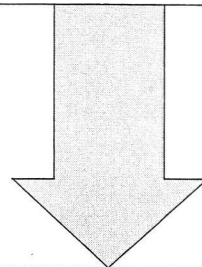
  

DATE			
LAST NAME		FIRST	M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			



IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		<b>2</b>
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		<b>4</b>
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	



GETTING TO KNOW YOU		<b>3</b>
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:		
RELATIONSHIP:		
YOU WERE REFERRED TO US BY		
NAME:		
PERSON TO CONTACT FOR EMERGENCY		
NAME:		
CELL NUMBER		
HOME NUMBER		
ADDRESS		
CITY	STATE	ZIP

## CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
- 6 Cell 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. My cell phone number is (include area code) \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Patient Name

# DENTAL HISTORY

Patient Account No.

Medical Alert

*Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No If yes, please describe: \_\_\_\_\_

### Are any of your teeth sensitive to:

Hot or cold? ..... Yes No

Sweets? ..... Yes No

Biting or Chewing? ..... Yes No

Have you noticed any mouth odors or bad tastes? ..... Yes No

Do you frequently get cold sores, blisters or any other oral lesions? ..... Yes No

Do your gums bleed or hurt? ..... Yes No

Have your parents experienced gum disease or tooth loss? ..... Yes No

Have you noticed any loose teeth or change in your bite? ..... Yes No

Does food tend to become caught in between your teeth? ..... Yes No

If yes, where \_\_\_\_\_

### Do you:

Clench or grind your teeth while awake or asleep? ..... Yes No

Bite your lips or cheeks regularly? ..... Yes No

Hold foreign objects with your teeth? (pencils, pipe, etc.) ..... Yes No

Mouth breathe while awake or asleep? ..... Yes No

Have tired jaws, especially in the morning? ..... Yes No

Snore or have any other sleeping disorders? ..... Yes No

Smoke/chew tobacco or use other tobacco products? ..... Yes No

### Have you ever had:

Orthodontic treatment? ..... Yes No

Oral Surgery? ..... Yes No

Periodontal treatment? ..... Yes No

Your teeth ground or the bite adjusted? ..... Yes No

A bite plate or mouth guard? ..... Yes No

A serious injury to the mouth or head? ..... Yes No

Please describe, including cause \_\_\_\_\_

### Have you experienced:

Clicking or popping of the jaw? ..... Yes No

Pain? (joint, ear, side of face) ..... Yes No

Difficulty in opening or closing the mouth? ..... Yes No

Difficulty in chewing on either side of the mouth? ..... Yes No

Headaches, neckaches or shoulder aches? ..... Yes No

Sore muscles (neck, shoulders)? ..... Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to replace your silver fillings? ..... Yes No

Would you like to keep all of your teeth all of your life? ..... Yes No

Do you feel nervous about having dental treatment? ..... Yes No

Please describe \_\_\_\_\_

Have you ever had an upsetting dental experience? ..... Yes No

Please describe \_\_\_\_\_

Have you ever been told to take a pre-medication prior to dental treatment? ..... Yes No

Is there anything else about having dental treatment that you would like us to know? ..... Yes No

If yes, please describe \_\_\_\_\_

(Please complete other side)