Date: _____

ALBERT JOAQUIN DDS
DENTAL REGISTRATION AND HISTORY FORM

PATIENT INFORMATION

Patient Name: _____
Last Name

_____
First Name MI

Address: _____

_____
City State Zip

Home Phone: _____Work: _____

Cell: _____ Email: _____

Sex: ☐M ☐F **Birth Date:** _____

Employer/School: _____Occupation: _____

Whom may we thank for referring you? _____

☐Phone Book ☐Internet/website ☐Drive by

EMERGENCY CONTACT INFO

Whom should we contact in case of emergency?

Name: _____ Relationship: _____

Home Phone: _____Cell/Work_____

Physician's Name: _____

Phone Number: _____

RESPONSIBLE PARTY/INSURANCE

Name of person(s) responsible for this account:

_____

Relationship to patient: _____

Address (if different): _____

City/St/Zip: _____

Home Phone: _____

PRIMARY INSURANCE:

Insurance Company: _____

Employer Name: _____

Insured's Name: _____

Group #: _____ Insured's ID # (or SS#): _____

Date of Birth: _____Relationship to Patient: _____

SECONDARY INSURANCE:

Insurance Company: _____

Employer Name: _____

Insured's Name: _____

Group #: _____ Insured's ID # (or SS#): _____

Date of Birth: _____Relationship to Patient: _____

RESPONSIBLE PARTY AND INSURANCE AUTHORIZATION

1. 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 up to a 1 1/2% late charge per month (18% APR) may be added to my account.

2. If applicable, I certify that I and/or my dependent(s) have insurance coverage with _____ and
Name of Insurance Company

   assign directly to Dr. Albert Joaquin all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

3. Dr. Albert Joaquin may also use my health care information (and that of my dependents) and may disclose such information to any insurance company with which I have coverage and their agents for the sole purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

4. I understand that my dental insurance carrier may pay less than the actual bill for services. All amounts not paid by any third party will be my responsibility. Please refer to our Financial Policy for complete details.

_____ _____
Signature of Patient/Parent/Responsible Party Date

DENTAL HISTORY

Please circle all that apply to you:

Bad Breath	Dry Mouth	Grind or Clench Teeth	Sensitive Teeth
Bite Lips, Cheeks, or Tongue	Food Collects Between Teeth	Have or Had Braces	Shifting Teeth
Biting Pain in Teeth	Fingernail Biting	Jaw Clicks or Pops	Smoke or Chew Tobacco
Bleeding Gums	Gum Disease	Jaw or Ear Pain	Sore or Lump in Mouth
Broken Fillings or Teeth	Gum Surgery	Loose Teeth	Trauma to Head, Neck, or Jaw
Cold Sores on Lips	Gums Swollen/Tender	Mouth Breathing	Yellowed or Stained Teeth

I wish my teeth were_____.

Date of last dental visit: _____ Last dental X-rays: _____ How often do you brush?_____ Floss? _____

HEALTH HISTORY

Please answer the following questions regarding your health history. Even though it may seem unnecessary, answering the questions honestly and fully will help us treat you more effectively and safely. Every question has some potential relation to your dental treatment. All information will be held in strict confidence.

Please circle if you have ever had any of the following conditions:

Alcoholism	Cough, persistent	High Blood Pressure	Rheumatoid Arthritis
Anemia	Diabetes	HIV/AIDS	Shortness of Breath
Arthritis or Gout	Drug Use, Abuse, or Addiction	Hypoglycemia	Sinus Trouble
Artificial Heart Valves	Emphysema	Intestinal Disease	Skin Rash
Artificial Joint (Hip/Knee)	Epilepsy/Seizures	Kidney Dialysis	Stroke
Asthma	Excessive Bleeding	Kidney Disease	Swollen Feet or Ankles
Autoimmune Diseases	Fainting or Dizziness	Liver Disease	Thyroid Problems
Blood Clots	Glaucoma	Low Blood Pressure	Tuberculosis
Blood Disease	Headaches	Lupus	Tumor, Head or Neck Area
Cancer	Heart Attack or Failure	Memory Problems/Alzheimer's	Ulcers or Stomach Problems
Chemotherapy	Heart Rhythm problems	Mental Health Issues	Weight Loss, unexplained
Chest Pain/Angina	Heart Surgery	Pacemaker or Defibrillator	Other (explain):
Circulatory Problems	Hepatitis Type(s) _____	Radiation Treatment	_____
Congenital Heart Lesions	Herpes	Respiratory Disease	None of the above

Women: Are you pregnant or trying to get pregnant? Yes ☐ No ☐ If yes, due date _____
Are you taking oral contraceptives? Yes ☐ No ☐ Nursing? Yes ☐ No ☐

ALLERGIES

Please check if you are allergic (itching, redness, rash, swelling of hands, feet, eyes, or lips) to any of the following?

☐Acrylic ☐Barbiturates (sleeping pills) ☐Codeine
☐Latex ☐Local Anesthetics ☐Metals or Jewelry
☐Penicillin ☐Sulfa Drugs ☐Other _____

MEDICATIONS YOU TAKE

_____ _____
_____ _____
_____ _____
_____ _____

I certify that I have read and understand the above information to the best of my knowledge and that the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I acknowledge that I am responsible for informing the doctor about any changes in my health history prior to any treatment. I agree to the use of anesthetics and other medication as necessary and understand that using anesthetic agents embodies certain risks. I can ask for a complete list of possible complications at any time.

_____ _____
Signature of Patient/Parent/Responsible Party Date