

Patient Registration Form

American Dental Association
www.ada.org

Email:			Today's Date:		
Preferred Name: <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Referred by:		
Name: Last First Middle		Home Phone: <i>include area code</i> () ()	Cell Phone: <i>include area code</i> () ()		
Address: Mailing address		City:	State:	Zip:	
SS#:		Date of Birth:	Sex: M F		
Employer:			Business Phone: <i>include area code</i> () ()		
Emergency Contact:		Relationship:	Home Phone: <i>include area code</i> () ()	Cell Phone: <i>include area code</i> () ()	
College Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Please provide school info:			School Name: _____		
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired			Address: _____		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Address 2: _____		
Pref. Pharmacy:		Phone: () ()	City, State, Zip: _____		

Dental Insurance Information

Primary Insurance Information	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	
Secondary Insurance Information	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	

Dental Information

For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time?			
Are you currently experiencing dental pain or discomfort? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Date of last dental x-rays:			

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

<p>(Check DK if you Don't Know the answer to the question) Yes No DK</p> <p>Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Physician Name: _____</p> <p>Phone: include area code (_____) _____</p> <p>Address/City/State/Zip: _____</p> <hr/> <p>Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what condition was treated? _____</p> <hr/> <p>Date of last physical exam: _____</p> <p>Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment Began: _____</p>	<p style="text-align: right;">Yes No DK</p> <p>Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what was the illness or problem? _____</p> <p>Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____</p> <hr/> <p>Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you:</p> <p>Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormone replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
--	--

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?

Date: _____ If yes, have you had any complications? _____

Allergies - Are you allergic to, or have you had a reaction to: Yes No DK

To all **yes** responses, specify type of reaction.

Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbituates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay fever / seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Yes No DK	Yes No DK	Yes No DK	Yes No DK
Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Mitral valve prolapse ... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Artificial heart valves ... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, date: _____	Diabetes Type I or II... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mental health disorders. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cardiovascular disease. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV infection... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Recurrent infections ... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune disease... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	G.E. Reflux/Persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Type of infection: _____
Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis ... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Coronary artery disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Systemic lupus erythematosus. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves. . <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure. ... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Emphysema. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe headaches/ Migraines. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
High blood pressure ... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epilepsy. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Cancer/Chemotherapy/ Radiation treatment. . <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Excessive urination ... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: (_____) _____

Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices



* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Patient Financial Agreement



Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. If a procedure requires multiple appointments, payment is required *in full* at the first appointment.

Payment Options:

- Cash
- Check
- MasterCard
- Visa
- CareCredit
- Credit card authorization for recurring charges
 - Treatment exceeds \$1,000
 - Plan may not exceed 3 months

Patients with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child: Financial arrangements must be made PRIOR to appointment. (Check, Cash or Credit card authorization.)

Parents accompanying their children are financially responsible for payment.

18% annual interest is charged for any unpaid balance. There is a \$30.00 processing charge for non-sufficient funds or returned checks.

Records can be viewed at any time. There is a nominal charge for release or copies of records. Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a \$50 charge for changed or broken appointments less than 48 hours in advance.

I, _____, agree to these financial terms.

Signature _____ Date: _____