Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

PATIENT INFORMATION

REGISTRATION *(Please Print)*

Home Phone _____

Name _____ (Last Name / First / Initial) Soc. Sec. # _____ Cell _____

Street Address _____ City _____ State _____ Zip _____

If student, permanent address _____ City _____ State _____ Zip _____

Sex ◉ M ○ F Age _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Minor

Birthdate _____ E-mail Address _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

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 / Initial) Relation to Patient _____

Birthdate _____ Soc. Sec. # _____ Daytime Phone _____

Address (if different from Patient) _____ City _____ State _____ Zip _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Dental Insurance Co. _____ Phone Number _____

Contract # _____ Group # _____

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional Dental Insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____ Phone _____

Address (if different from Patient) _____ City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Dental Insurance Co. _____ Phone Number _____

Contract # _____ Group # _____ Soc. Sec. # _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Signature of patient *(or parent / guardian if minor)*

DENTAL HEALTH HISTORY

(Confidential)

Today's date _____

Patient Name _____ (Last Name) (First) (Initial) Birthdate _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____ Phone _____

Address _____ City _____ State _____ Zip _____

Business Address _____ Business Phone _____

Date of last dental cleaning _____ Date of last dental x-rays _____ Do you wear dentures or partials? _____

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

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking / popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sores / growths in mouth
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sensitivity to cold

How often do you floss? _____ How often do you brush? _____ Do you like your smile? _____

MEDICAL HISTORY

Physician's Name _____ Address _____ Phone _____

Have you had any serious illness or operation? _____ If yes, describe _____

Have you ever 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 or had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis / Rheumatism
- ☐ Artificial Heart Valve
- ☐ 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
  Describe _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet / Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS / PURPOSE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Pharmacy Name _____ Phone _____

ALLERGIES

- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Barbiturates (Sleeping Pills)
- ☐ Demerol
- ☐ Codeine
- ☐ Latex
- ☐ Other _____
- ☐ Local Anesthetic
- ☐ Penicillin / Amoxicillin
- ☐ Sulfa
- ☐ Valium
- ☐ Iodine

SIGNATURE

The above 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.

Date _____ Signature _____