DENTAL REGISTRATION FORM

PATIENT INFORMATION

Last Name:____________________ First Name:____________________ Middle Initial:__________

Preferred Name:____________________ DOB:______________ SSN#:____________________

Address:____________________ City:______________ State:__________ Zip code:__________

Home#:________________ Cell#:________________ Work#:________________

E-mail:____________________ *EMERGENCY CONTACT (someone who does not live with you):*

Sex: ☐ MALE ☐ FEMALE *Name:*________________ *Relationship:*________________

Marital Status: ☐ Single ☐ Married *Address:*____________________

☐ Divorced ☐ Widowed *Home#:*________________ *Cell#:*________________

PARENT/GUARDIAN *(if patient is minor)*

Primary Guardian's Name:____________________ DOB:__________ Relation to Patient:______________

Address: ____________________ SSN#:______________ Occupation:______________

City/State/Zip code:____________________ Cell#:______________ Work#:______________

E-mail:____

Primary Guardian's Name:____________________ DOB:__________ Relation to Patient:______________

Address: ____________________ SSN#:______________ Occupation:______________

City/State/Zip code:____________________ Cell#:______________ Work#:______________

E-mail:____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this patient?______________ Relationship:______________ SSN#:______________

Address:____________________ City/State/Zip code:____________________

Home#:________________ Cell#:________________ Work#:________________

E-mail:____

DENTAL/ORTHODONTIC INSURANCE

Primary policy holder's Full Name:____

Date of Birth:______________ Social Security #:______________ Relation to patient:______________

Address:____________________ City/State/Zip Code:____________________

Employer: ____________________ Address:____________________

Insurance Company:____________________ Group#:______________ ID#:______________

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know Phone#:______________

Secondary policy holder's Full Name:____

Date of Birth:______________ Social Security #:______________ Relation to patient:______________

Address:____________________ City/State/Zip Code:____________________

Employer: ____________________ Address:____________________

Insurance Company:____________________ Group#:______________ ID#:______________

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know Phone#:______________

NOTICE OF PRIVACY

Acknowledgement of Receipt of Notice of Privacy Practices Posted.
Copies available upon request.

I have read over this office's Notice of Privacy Practices records and materials.

X____________________________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
[ ] Communication barriers prohibited obtaining acknowledgement
[ ] An emergency situation prevented us from obtaining acknowledgement
[ ] Other, *specify*____________________

AUTHORIZATION

I authorize the Provider to release any information including the diagnosis and records of treatment or examination rendered to the patient during the period of such are to third party payers and/or other health practitioners. I authorize and request my insurance company to assign benefits and pay directly to the Provider or Provider's group those insurance benefits. I understand that my insurance carrier may pay less than the actual bill for services. I authorized the use of my signature on all insurance submissions. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____
Patient/Parents/Guardian Printed Name

X____
Patient/Parents/Guardian Signature *Date*

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Dental and Medical History Form

Patient Name: ______________________ Birth Date: ______________________

Although we primarily treat the area in and around the mouth, one's mouth is a part of the entire body. Previous health problems and/or medication could have an important interrelationship with the dentistry the patient will receive. Please answer each of the following questions as completely as possible. Thank you!

Dental History

Reason for today's visit:
____
____
Former Dentist: ______________________
City/State: ______________________
Phone: ______________________
Date of last dental visit:______________________
Date of last X-rays: ______________________
Place [X] on any following that apply:

- ☐ Bad breath
- ☐ Bleeding/swollen gums
- ☐ Bleeding abnormally, with extraction or surgery
- ☐ Blisters on lips/mouth
- ☐ Dry mouth
- ☐ Sucking finger
- ☐ Lip biting
- ☐ Fingernails chewing/biting
- ☐ Grinding teeth
- ☐ Jaw clenching/pain
- ☐ Loose teeth/broken fillings
- ☐ Pain when brushing
- ☐ Sensitive to cold
- ☐ Sensitive to heat
- ☐ Sensitive to sweet
- ☐ Sensitive when biting
- ☐ Orthodontic treatment
- ☐ Periodontal treatment

How often do you floss?
____

How often do you brush?
____

Medical History

Physician's Name: ______________________ Last visit date: ______________________

Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes,______________________
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes,______________________
Do you take/have taken Phen-Fen or Redux?	☐ Yes ☐ No	If yes,______________________
Are you on a special diet?	☐ Yes ☐ No	If yes,______________________
Are you currently taking any medications	☐ Yes ☐ No	If yes,______________________
WOMEN:		
Are you pregnant?	☐ Yes ☐ No	If yes,______________________
Are you nursing?	☐ Yes ☐ No	If yes,______________________
Taking Oral Contraceptives?	☐ Yes ☐ No	If yes,______________________

Place [X] if you are allergic to any of the following:

☐ Aspirin	☐ Penicillin	☐ Acrylic	☐ Latex	☐ Metal
☐ Codeine	☐ Sleeping pills	☐ Iodine	☐ Local anesthetics	☐ Sulfa

Other allergies: ______________________

Place [X] on any following that apply:

- ☐ ADD/ADHD
- ☐ AIDS/HIV positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina/Chest pain
- ☐ Anxiety Disorder
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism
- ☐ Blood disease
- ☐ Blood transfusion
- ☐ Breathing problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold sores/Fever blisters
- ☐ Congenital Heart Disorder
- ☐ Cortisone Medicine
- ☐ Cough, persistent or bloody
- ☐ Diabetes 1
- ☐ Diabetes 2
- ☐ Emphysema
- ☐ Epilepsy or Seizures **
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Problem/Disease
- ☐ Heart Pacemaker
- ☐ Heart Murmur **
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives/Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problem
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problem
- ☐ Parathyroid Disease
- ☐ Psychic Care
- ☐ Radiation Treatment
- ☐ Renal Dialysis
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Swollen Neck Glands
- ☐ Thyroid Problem
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Weight Loss
- ☐ Yellow Jaundice

**If Heart Murmur, do you require antibiotics prior to dental treatment? ☐ Yes ☐ No
If yes, ______________________

**Epilepsy or Seizures, when was that last seizure?
____

Other illness or health condition that not listed above: ______________________
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services that I may need.

X______________________ Date: ______________________
Signature of Patient/Parent or Guardian

This form has been reviewed with Patient/Parent or Guardian and conditions accurately notated.

X______________________ Date: ______________________
Signature of Providing Dentist

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