PATIENT REGISTRATION FORM

Patient Name: (please print) ____
last first middle

Social Security Number: ______________________ Date of Birth: ____/____/____

Gender: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widow

Address: ____

City: ______________________ State: _______ _____ Zip code: ______________

Email address: ____

Home Phone: ____________ Business Phone: ____________ Cell Phone: ____________

Employer (company): ______________________ Occupation: ______________

Name of the person to be billed (Guarantor): ______________________________

Name of person to be notified in case of emergency: ______________________

Address of that person: ____

Phone: ______________________ Relationship: ______________________

Whom may we thank for your referral: ______________________________

DENTAL INSURANCE INFORMATION

1st Dental Insurance: ______________________

Policy Holder: ______________________ □ Male □ Female

SSN/ID: ______________ DOB: __________

Relationship: □ Spouse □ Child □ Other Group#: __________

Employer: ______________________

2nd Dental Insurance: ______________________

Policy Holder: ______________________ □ Male □ Female

SSN/ID: ______________ DOB: __________

Relationship: □ Spouse □ Child □ Other Group#: __________

Employer: ______________________

The above information is true and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between Doctor and Patient and/or Guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated. I understand that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 1.5% will be applied, per month, to accounts past due 60 days or more.

INITIAL: ____________

HMO/DHMO Policy Holder please check the box and signature below for the acknowledgement.

☐ I, ______________ certify that I am aware of my pre-paid plan provisions regarding eligibility requirement, patient portion co-payment, excluded services and broken/cancelled appointment charges. I understand that I am responsible for fees incurred.

INITIAL: ____________

GENERAL HEALTH INFORMATION

DATE: ____________________ CHART #______________

PATIENT NAME: ______________ (LAST) ______________ (FIRST) BIRTH DATE: ________ AGE: ________

DENTAL HISTORY

1. **Reason for Visit / Main Concern**? Check-Up ❑ Cleaning ❑ Toothache ❑ Other______________
2. Are there other conditions of which we should be aware? YES ❑ NO ❑ If yes, please specify: ______________
3. When did you last visit a dentist? ______________
4. What treatment was performed? ______________
5. Was the treatment completed? ______________
6. When were dental x-rays taken? ______________
7. Did you have a cleaning ? YES ❑ NO ❑
8. Have you had gum (periodontal) treatment? YES ❑ NO ❑
9. Have you ever had prolonged bleeding after an extraction? YES ❑ NO ❑ If yes, please specify: ______________
10. Have you had any problems with past dental treatment? YES ❑ NO ❑ If yes, please specify: ______________
11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES ❑ NO ❑ If yes, please specify: ______________
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES ❑ NO ❑ If yes, please specify: ______________
13. Do your gums bleed easily? YES ❑ NO ❑
14. Do you feel you have bad breath? YES ❑ NO ❑
15. Are your teeth sensitive to hot or cold? YES ❑ NO ❑
16. Would you like your teeth whiter? YES ❑ NO ❑
17. Are you happy with your smile? YES ❑ NO ❑ If no, please explain: ______________

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES ❑ NO ❑ If yes, please specify: __________ Dr. Name: ______________
   Dr. Phone: (   ) ______________
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? ______________
3. Are you taking any medications at this time, including birth control? YES ❑ NO ❑ If yes, please specify: ______________
4. (Woman) Are you pregnant at this time? YES ❑ NO ❑ If yes, please specify how many months: ______________
5. Are there any other health problems of which we should be advised? Please specify: ______________
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"			Doctor Comments	Please check "YES" or "NO"			Doctor Comments
ARTIFICIAL Heart Valve	YES ❑	NO ❑		HEPATITIS	YES ❑	NO ❑	
AIDS/HIV+	YES ❑	NO ❑		HIGH BL. PRESSURE	YES ❑	NO ❑	
ANEMIA	YES ❑	NO ❑		JAUNDICE	YES ❑	NO ❑	
ANGINA	YES ❑	NO ❑		JOINT REPLACEMENT	YES ❑	NO ❑	
ARTHRITIS	YES ❑	NO ❑		KIDNEY DISEASE	YES ❑	NO ❑	
ASTHMA	YES ❑	NO ❑		LATEX ALLERGY	YES ❑	NO ❑	
BLEEDING PROBLEMS	YES ❑	NO ❑		LIVER PROBLEMS	YES ❑	NO ❑	
CANCER	YES ❑	NO ❑		LOW BL. PRESSURE	YES ❑	NO ❑	
CHEMO/RAD THERAPY	YES ❑	NO ❑		LUNG DISEASE	YES ❑	NO ❑	
COSMETIC SURGERY	YES ❑	NO ❑		PACEMAKER	YES ❑	NO ❑	
DIABETES	YES ❑	NO ❑		PHEN-FEN	YES ❑	NO ❑	
DIZZY SPELLS	YES ❑	NO ❑		PSYCHIATRIC CARE	YES ❑	NO ❑	
DRUG ADDICTION	YES ❑	NO ❑		RHEUMATIC FEVER	YES ❑	NO ❑	
EMPHYSEMA	YES ❑	NO ❑		SINUS TROUBLE	YES ❑	NO ❑	
EPILEPSY	YES ❑	NO ❑		SLEEP APNEA	YES ❑	NO ❑	
FAINTING	YES ❑	NO ❑		SMOKING TOBACCO	YES ❑	NO ❑	
GLAUCOMA	YES ❑	NO ❑		STROKE	YES ❑	NO ❑	
HEART ATTACK	YES ❑	NO ❑		THYROID PROBLEMS	YES ❑	NO ❑	
HEART SURGERY	YES ❑	NO ❑		TMD OR TMJ	YES ❑	NO ❑	
HEART MURMUR	YES ❑	NO ❑		TUBERCULOSIS	YES ❑	NO ❑	
HEART PROBLEMS	YES ❑	NO ❑		VENEREAL DISEASE	YES ❑	NO ❑	

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature ______________________________ Date ______________
(Parent if Patient is a Minor)
Doctor Signature ______________________________

MEDICAL UPDATE:

1. Patient's signature ______________ Doctor's Signature ______________ Date ______________
2. Patient's signature ______________ Doctor's Signature ______________ Date ______________
3. Patient's signature ______________ Doctor's Signature ______________ Date ______________

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