



PATIENT REGISTRATION

Welcome! We want to provide you with the best possible care. Please assist us by thoroughly answering all the questions below. All information is completely confidential.

NAME _____ Birth date _____ Age ____ SSN _____

Preferred name _____

Street _____ Phone# _____

City _____ Cell # _____

State _____ Zip _____ E-mail _____

Employer _____ How long held? _____

Insurance _____ Group No. _____

Insurance I.D. No. _____

SPOUSE/GUARDIAN NAME _____ Birth date _____ Age ____ SSN _____

Street _____ Phone# _____

City _____ Cell # _____

State _____ Zip _____ E-mail _____

Employer _____ How long held? _____

Insurance _____ Group No. _____

Insurance I.D. No. _____

In case of emergency, who should be notified? _____

Phone _____ Relation _____

BILLING INFORMATION

Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Phone _____ E-mail _____

Who may we thank for referring you? _____

Signature _____ Date _____

this space is intentionally left blank

CONSENT FOR TREATMENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient)_____’s dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents or medication carries certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor’s or designated staff’s use and disclosure of any oral, written or electronic records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

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 a late charge (12 % APR) may be added to my account. If required, I also understand a check of my credit history be made.

Patient’s signature_____ Date _____

Parent/Responsible party’s signature_____ Relationship to Patient_____



DENTAL HISTORY

Name _____ Date _____ Birth date _____ Age _____

Please answer each of the following questions. If in doubt, please leave blank.

1. Reason for appointment _____
2. Date of last dental visit _____ Last Cleaning _____ X-Rays _____
 Previous dentist's name _____
 Address _____ State _____ Zip _____
3. Do you have any dental problems now? **YES** **NO**
 Please describe _____
4. What issues do you want to address today? _____

	YES	NO	HAVE YOU EXPERIENCED?	YES	NO
Are your teeth sensitive? If yes, please describe _____	<input type="checkbox"/>	<input type="checkbox"/>	Clicking or popping of the jaw? Pain? (joint, ear, side of face) Difficulty in opening/closing mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have your parents experienced gum disease or tooth loss?	<input type="checkbox"/>	<input type="checkbox"/>	Headaches, neck aches or shoulder aches? Sore muscles (neck, shoulder)	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently get cold sores, blisters or other oral lesions?	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel nervous about having a dental treatment? If yes, please describe _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed loose teeth or any change in your bite?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Does food tend to be caught in between your teeth? If yes, where? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Do you clench or grind your teeth while awake or asleep?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an upsetting dental experience? If yes, please describe _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you breathe through your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Do you have tired jaws, especially in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	What can we do to make your dental visits more pleasant? Please describe _____		
Do you snore or have sleeping disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Do you smoke/chew tobacco or use other products?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Have you seen a dental specialist?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Have you had a serious injury to the mouth or head? If yes, please describe _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		

5. What are your long term desires for your teeth/dental health?

6. Have you ever been told that you needed to be pre-medicated with antibiotics prior to treatment? **YES** **NO**

7. Rate the health of your mouth now **POOR** -- 1 2 3 4 5 -- **EXCELLENT**

8. Rate the satisfaction of your smile **UNSATISFIED** -- 1 2 3 4 5 -- **HIGHLY SATISFIED**

For doctor/staff use only

HEALTH HISTORY

Please take the time to completely answer the following questions. All information is completely confidential. Doing so will allow your dentist and staff to treat you appropriately, according to your needs.

Name _____ Date _____ Birth date _____ Age _____

Please answer each of the following questions. If in doubt, please leave blank.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you in good health now? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you under the care of a physician? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what is the condition being treated? _____ | | |

3. Physician's Name _____ Phone _____

4. Do you have or have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
GENERAL			RESPIRATORY			DIGESTIVE SYSTEM		
Tire easily, weakness	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Marked weight change	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
On a diet	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/hayfever	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Supervised diet	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Bloody sputum	<input type="checkbox"/>	<input type="checkbox"/>	URINARY		
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing while lying down	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
SKIN			ENDOCRINE			Increase in frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>
Rash/hives	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bloody urine	<input type="checkbox"/>	<input type="checkbox"/>
Change skin color	<input type="checkbox"/>	<input type="checkbox"/>	Family history of diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Thyroid condition/goiter	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD		
Visual change	<input type="checkbox"/>	<input type="checkbox"/>	HEART/BLOOD VESSELS			Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
EARS			Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/discomfort	<input type="checkbox"/>	<input type="checkbox"/>	OTHER		
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/trouble	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
NOSE			Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	2+ drinks/day	<input type="checkbox"/>	<input type="checkbox"/>
THROAT			Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol dependency	<input type="checkbox"/>	<input type="checkbox"/>
Soreness/hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco dependency	<input type="checkbox"/>	<input type="checkbox"/>
NERVOUS SYSTEM			Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Drug dependency	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/ARC, HIV	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Ever had a serious illness	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Ever had a serious accident	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	BONE/MUSCLES			Ever had excessive		
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	bleeding after extraction	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Cuts take long time to heal	<input type="checkbox"/>	<input type="checkbox"/>

5. Are you pregnant? YES NO

If yes, what month? _____

Are you taking birth control pills? YES NO

6. Are you allergic or have you ever experienced any

reaction to the following? **YES** **NO**

- | | | |
|--------------------------------------|--------------------------|--------------------------|
| Local anesthetics (e.g. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbituates/sedatives/sleeping pills | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin/sulfa/other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin or codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex | <input type="checkbox"/> | <input type="checkbox"/> |
| Other allergies _____ | | |

6. Are you taking any of the following? **YES** **NO**

- | | | |
|--|--------------------------|--------------------------|
| Antibiotics/sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood thinners | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone/steroids | <input type="checkbox"/> | <input type="checkbox"/> |
| Antihistamines/allergy drugs/cold remedies | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin/other diabetes drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Recreational drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Digitalis/other heart medications | <input type="checkbox"/> | <input type="checkbox"/> |
| Nitroglycerin | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin/ibuprofen/acetaminophen | <input type="checkbox"/> | <input type="checkbox"/> |
| Fossamax, Boniva, Actonel, Zometa? Please specify. | | |
| Other medication _____ | | |

If yes to any of the above, list name of medication and dosage below.

1. _____ 2. _____
 3. _____ 4. _____

7. Is there any disease, condition or problem not listed above that you think we should know about or any activity you cannot do? If so explain _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at my next appointment.

Signature of Patient (or Parent or Guardian) _____

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