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Patient Registration Form

American Dental Association
www.ada.org

Email:			Today's Date:
Preferred Name: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.		Referred by:	
Name: Last First Middle		Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )
Address: Mailing address		City:	State: Zip:
SS#:		Date of Birth:	Sex: M F
Employer:			Business Phone: *include area code* ( )
Emergency Contact:	Relationship:	Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )

Dental Insurance Information

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec. or ID #: _____ 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: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec. or ID #: _____ 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	?
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Have you been diagnosed with sleep apnea?	❑	❑	❑
If yes, what are you currently taking to treat it? _____			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	?
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

over

Medical Information

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

(Check DK if your Don't Know the answer to the question)	Yes	No	?
Are you now under the care of a physician?	❑	❑	❑
Physician Name: _____			
Phone: include area code (_____) _____			
Address/City/State/Zip: _____			
_____			
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
If yes, what condition was treated? _____			
_____			
Date of last physical exam: _____			
Do you wear contact lenses?	❑	❑	❑
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)?	❑	❑	❑
Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?	❑	❑	❑
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 metastic cancer?	❑	❑	❑
Date Treatment Began: _____			

	Yes	No	?
Have you had a serious illness, operation or been Hospitalized in the past 5 years?	❑	❑	❑
If yes, what was the illness or problem? _____			
Are you talking or have you recently taken any prescription or over the counter medicine(s)?	❑	❑	❑
If so, please list all, including vitamins, natural or herbal preparations and/ or diet supplements: _____			
_____			
_____			
Do you use controlled substances (drugs)?	❑	❑	❑
Do you use tobacco (smoking, snuff, chew, bidis)?	❑	❑	❑
If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	❑	❑	❑
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week?			
WOMEN ONLY Are you:			
Pregnant?	❑	❑	❑
Number of weeks:			
Taking birth control pills or hormones replacement:	❑	❑	❑
Nursing?	❑	❑	❑

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

	Yes	No	?		Yes	No	?
Local anesthetics _____	❑	❑	❑	Metals _____	❑	❑	❑
Aspirin _____	❑	❑	❑	Latex (rubber) _____	❑	❑	❑
Penicillin or other antibiotics _____	❑	❑	❑	Iodine _____	❑	❑	❑
Barbiturates, sedatives, or sleeping pills _____	❑	❑	❑	Hay fever / seasonal _____	❑	❑	❑
Sulfa drugs _____	❑	❑	❑	Animals _____	❑	❑	❑
Codeine or other narcotics _____	❑	❑	❑	Food _____	❑	❑	❑
				Other _____	❑	❑	❑

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

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, in 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: _____

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APPOINTMENT CANCELLATION POLICY

To Our Patients:

In order to help control our schedule so we can efficiently provide care, and to keep our fees at reasonable rates, we have an appointment cancellation policy. If you need to change or you fail an appointment for any reason, we reserve the right to charge for that cancellation with less than 48 hours notice.

If you need to cancel or reschedule an appointment for a visit or procedure, please do so a minimum of 48 hours prior.

This allows us to offer that time to our other patients.

For less than 48 hours notice, we will charge a cancellation fee of $95.

Please note that business hours are from 8AM to 5PM, Monday through Thursday. Cancellation messages left after hours with less than 48 hours notice are not acceptable and you may be charged according to this policy. By signing this, you understand that if you cancel your appointment ***less than 48 hours before your scheduled appointment,*** you may be charged the ***$95*** cancellation fee.
We appreciate your cooperation.

_____ _____

Patient Name Date

Your dental experience is very important to us. There are many options available to improve your comfort. How would you have changed your past visits and what would you like us to do in the future?

The success of any dental treatment is dependent on many factors including pre-existing periodontal destruction, jaw joint problems, your general physical health, previous dental care and experiences, and your willingness to perform proper oral hygiene and to stay on a recall program after active therapy is completed. The most important aspect is that the procedures you decide to have done are those that you believe are the right ones for you at the time they are accomplished. In complicated, potentially expensive situations, we will offer you a variety of treatment plans, and we request that you take an active role in developing the treatment plan that best meets your wants and needs. In all cases we will attempt to provide the maximum amount of care, skill and judgment for you regardless of which procedures you choose. Your involvement and understanding are a primary ingredient to the long-term success of your dental treatment.

PAYMENT POLICIES

Patients are responsible for payment at the time of treatment regardless of Insurance coverage. We will be happy to assist you in claiming benefits you may have under a dental insurance plan, providing the benefits are assigned to us. We will attempt to inform you of your co-pay. You are responsible for any balance your insurance does not pay. If you have any questions, please feel free to discuss them with the front office.

1. All patient costs are due at time of service.
2. We accept Visa, Discover and MasterCard.

PLEASE READ AND SIGN THE FOLLOWING:

I have completed the registration and health history form and the information I have provided is true and complete. I have also read the privacy and payment policies and I understand them.

Signature: _____ *Date:* _____