

**REGISTRATION FORM**

**Section I: Patient Information** Date \_\_\_\_\_

Name: \_\_\_\_\_ I Prefer to be called: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
 The best way to contact me is:  Email  Text Message  Call Home Phone  Call Cell Phone  Call Work Phone  
 Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Check Appropriate Box:  Minor  Single  Married  Widowed  Separated  Divorced  
 If Student, Name of School \_\_\_\_\_ City/State \_\_\_\_\_  FT  PT  
 Spouse or Parent's Name: \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_ Would you like to receive our e-newsletter?  Yes  No

**Section II Responsible Party**

Relationship to Patient:  Self  Spouse  Parent  Other  
 Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ SSN# \_\_\_\_\_

**Section III Insurance Information**

Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 SSN#: \_\_\_\_\_ Name of Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Address of Employer: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Grp # \_\_\_\_\_ ID# \_\_\_\_\_  
 Ins Co Address: \_\_\_\_\_ Ins Co. Phone: \_\_\_\_\_

----- DO YOU HAVE ANY ADDITIONAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING -----

Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 SSN#: \_\_\_\_\_ Name of Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Address of Employer: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Grp # \_\_\_\_\_ ID# \_\_\_\_\_  
 Ins Co Address: \_\_\_\_\_ Ins Co. Phone: \_\_\_\_\_

**INSURANCE ASSIGNMENT & RELEASE:** I hereby authorize my insurance benefits to be paid directly to the dentist. I am aware that I am financially responsible for any balance(s) due. Insurance reimbursement is a contract between the patient and their insurance company. We cannot accept responsibility for collecting insurance claims or for negotiating disputed claims.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

I understand that I am responsible for payment of my account within thirty (30) days unless other arrangements have been made in advance. I also understand that expenses incurred for the use of collection services will be added to my account and are my responsibility.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

## PATIENT MEDICAL HISTORY FORM

### MEDICAL HISTORY

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

<p>Are you under medical treatment now?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain: _____</p> <p>Are you taking any medication(s) including non-prescription? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain: _____</p> <p>Have you ever taken Fen-Phen/Redux? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any history of Chemotherapy? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any history of Bisphosphonate (Fosamax) use?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you use tobacco?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you use controlled substances? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting/Seizures..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy/Convulsions ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you wear contact lenses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you allergic to or have reactions to the following:</p> <p>Local anesthetics (e.g. Novocaine) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or Antibiotics..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metals (e.g. nickel, mercury, etc.)..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Rubber..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other (please list) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have a persistent cough or throat clearing not associated with common illness? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina / Chest Pain ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement/Implant..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis/Jaundice ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever/Allergies..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Therapy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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### DENTAL HISTORY

Previous Dentist & Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

<p>Do your gums bleed while brushing or flossing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are your teeth sensitive to hot or cold?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are your teeth sensitive to sweet or sour? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you feel pain to any of your teeth?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you had any head, neck or jaw injuries?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have frequent headaches? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you clench or grind your teeth? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you bite your lips or cheeks frequently? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Have you had difficult extractions in the past?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you had prolonged bleeding after extractions?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you had any orthodontic treatment? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you wear dentures or partials? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, date of placement _____</p> <p>Have you ever received oral hygiene instructions regarding the care of your teeth and/or gums? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you like your smile? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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### AUTHORIZATION & 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 patient/guardian if a minor)