PATIENT REGISTRATION

Patient's Name	Birthdate	Age	Today's Date
	Sex: M F		
Home Address	City	State	Zip
Please Circle One: Single, Married, Separated, Widow	Cell Phone		Home Phone Number
Your Employer	How Long Employed	Occupation	Work Phone
Are you a full time student? □Yes □ No	*If patient is minor we need:*	*Mother's Birthdate:*	*Father's Birth Date:*
Person responsible for account		Social Security number	
Name of spouse (Parent if minor)		E-mail address	Cell Phone
Spouse's (parent's) employer	Spouse's Soc. Sec. #		Work phone
How did you hear about our office?		EMERGENCY INFORMATION	
		Name, Address, & telephone of	
Reason for this visit		A Relative Not living with you.	

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have a secondary insurance coverage, complete this for the secondary coverage**
Insured's name DOB SS#	Insured's name DOB SS#
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone #	Phone #
Group # Local #	Group # Local #

Consent for Services

1. I hereby authorize the doctor or his designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name patient) _____'s dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by the doctor and the patient and to employ such assistance as required to provide proper treatment.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Financial Agreement

I understand that the payment of my bill is my legal obligation. All filings of insurance papers and confirmation of insurance payments to be made by my insurance carrier are my responsibility. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy. In the case that this account should become delinquent and is therefore placed in the hands of an Attorney for collection, I agree to pay attorney fees of 33 1/3% of the unpaid balance and interest owing, plus all court costs and interest (at a rate of 1.5% per month or 18% APR), beginning 30 days after the monies have become due or expenses have been incurred. I further agree to pay returned check charges of $25 per returned check. I have read the above conditions of treatment and payment and agree to their content. I also understand and agree that I am responsible for services rendered to my spouse and/or children.
A minimum charge of $50.00 will be made for failed and cancelled appointments without prior notice of 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment has been made, please remember this time has been reserved for you.

_____Date:_____Relationship to Patient:_____
Signature or Patient, parent or guardian

_____Date:_____Relationship to Patient:_____
Signature of guarantor of payment?responsible party

DENTAL HISTORY

Please check any of the following problems that apply to you.

-Sensitivity (hot, cold, sweet) ☐
Where? UR LR UL LL
-Headaches, earaches, neck pain ☐
-Jaw joint pain ☐
-Teeth or fillings breaking ☐
-Grinding or clenching teeth ☐
-Bleeding, swollen or irritated gums ☐
-Loose, tipped or shifting teeth ☐
-Bad breath ☐

Do you have or have you had any of the following?

-Dentures ☐
-Partial dentures ☐
-Braces ☐
-Periodontal (gum) treatments ☐

Please share the following dates:

-Your last cleaning ___ / ___
-Your last oral cancer screening ___ / ___
-Your last complete X-Rays ___ / ___

Name of Previous Dentist _____
City _____ **State** _____
Phone Number _____
What is the most important thing to you about your future smile and dental health? _____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐
Do you smoke or use chewing tobacco? ☐
How much? For how long?
If I could change my smile, I would: ☐
-Make them whiter ☐
-Make them straighter ☐
-Close spaces ☐
-Replace black metal fillings with tooth colored restorations ☐
-Repair chipped teeth ☐
-Replace missing teeth ☐
-Replace old crowns that don't match ☐
-Have a smile makeover ☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
-Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?
_____
What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ AIDS
☐ Allergies (Seasonal)
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Diabetes
☐ Dizziness
☐ Drug Addiction
☐ Emphysema
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Heart Conditions
☐ Heart Lesions (Congenital)
☐ Heart Murmur
☐ Heart Surgery
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ HIV Positive
☐ Jaundice
☐ Jaw Joint Pain
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervousness/Depression
☐ Pacemaker
☐ Phen Fen (1 month +)
☐ Pregnant Currently
☐ Radiation (head/neck)
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Seizures
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Venereal Diseases
☐ Other

Do you have any of the following drug allergies?

☐ Aspirin
☐ Darvon
☐ Nitrous Oxide
☐ Percodan
☐ Local Anesthetic
☐ Tetracycline
☐ Codeine
☐ Erythromycin
☐ Valium
☐ Penicillin
☐ Sulfa
☐ Other

Are you under a physician's care? What for?
_____
Are you taking any medications? What?
_____
Family Physician _____ **Phone Number** _____

Patient Signature (Parent of Child) _____ Date _____ Dentist Signature _____