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The Art And Science of Beautiful Smiles.

REGISTRATION FORM / MEDICAL-DENTAL HISTORY

PATIENT REGISTRATION FOR:_____

Date Of Birth_____

Residence
Address_____

Telephone_____ Referred By _____

Preferred Time for Appointments_____

SSN_____DOB_____

Email Address_____

Marital Status S M D W Spouses Name_____

If Minor Address
Name of Guardian_____ Telephone_____

Person Responsible for Fee (if other than patient) _____

Billing Address
(if different from above)_____

Occupation_____ Will you receive calls at work?_____

Work Phone _____

INSURANCE INFORMATION
PRIMARY CARRIER

Name of Ins. Co._____

Address_____

Phone_____

Subscribers Name / Relation to patient_____

Group Policy Number_____

MEDICAL HISTORY

INSTRUCTIONS:
To receive treatment in this office you must answer all questions of this history form. The questions asked relate directly to the safe and effective treatment you are to receive in the office-to the best of your ability honest answers must be given. If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with your doctor. Some of the questions may not relate to your medical condition; in that event you are to write N/A (not applicable) in the space provided. To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information."

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name, address & telephone of your physician._____

_____

2. Date of last visit to your doctor_____ Purpose of visit_____

3. Do you suffer from any disability? ____ If yes, describe_____

_____

4. Have you ever, or do you now take illegal drugs? _____ If yes, what drugs and when?

_____

Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

5. Do you have AIDS, or are you HIV-Positive?_____ If yes describe current status_____

_____

6. Do you now have, or have you ever had a venereal disease?_____ If yes describe_____

_____

7. Have you ever had, or do you now have hepatitis? _____ If yes describe_____

8. For females: Are you pregnant? _____ If yes, when are you due? _____

9. For females: Are you taking birth control pills?_____
Note: there are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills

10. **Are you taking any drugs or medications**? _____ If yes, list and describe amounts and purpose.

_____

_____

Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems.
Information about your current use of drugs and medication is essential.

11. Have you ever had an allergic reaction to medication? _____ If yes, describe_____

_____

12. Have you lost weight recently? _____ IF yes, describe_____

Have you ever had or been treated for:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?

_____

14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats?

_____

15. Stomach or intestinal disease? _____

16. Abnormal blood pressure, excessive bleeding, or anemia? _____

17. Breathing problems, asthma, tuberculosis, or hay fever? _____

18. Cancer, x-ray treatments, or chemotherapy? _____

_____

19. Diabetes?_____

20. Kidney problems or renal dialysis? _____

21. A stroke, convulsions, or fainting spells? _____

22. Tumors or growths?_____

23. Arthritis or rheumatism?_____

24. Have you ever had a major operation?_____ If yes, describe_____

_____

25. Have you ever had a serious injury to your head or neck?_____ If yes, describe _____

_____

26. Are you on a special diet? _____ If yes, for what reason, and describe_____

_____

27. Do you smoke?_____ If yes describe type and quantity_____

28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? _____ If yes, describe_____

29. Are there any other problems about your health of which you are aware?

_____

_____

_____

_____

_____

Dental History

Date of your last dental visit_____

Reason for your last visit (or series of visits)_____

Do you have any of your x-rays or dental records? If no could you please contact your previous office for any x rays?_____

WITH RESPECT TO ANY PREVIOUS DENTAL TREATMENT, HAVE YOU:

Ever fainted?_____

Had an allergic reaction?_____

Had abnormal bleeding?_____

Any other complications during or following dental treatment?_____ If yes describe_____

_____

Do your gums bleed on brushing or eating?_____

Does food catch between your teeth?_____

Are any of your teeth sensitive to heat cold or pressure?_____

Do you grind your teeth or clench your jaws?_____

Do you have pain or clicking in the jaw joint around your ear?_____

Are you apprehensive about dental treatment?_____

_____

Do you have any discolored teeth that bother you?_____

Would you like your smile to look better or different?_____

_____

Are there any sores in your mouth?_____

Do any of your teeth ache?_____

Do you have any other dental complaint?_____

_____

PLEASE CHECK ANY THAT ARE APPLICABLE

- ☐ I gag easily
- ☐ I feel out of control when I'm lying down in the dental chair.
- ☐ I have not been to a dentist in a long time, and feel uncomfortable about what you will say about my teeth.
- ☐ Pain relief is a top priority for me.
- ☐ Please tell me what I need to know about my mouth, in order to make an informed decision.
- ☐ I hate the noise of the drill.
- ☐ I want to know the cost up front. No money surprises please.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise.

NOTE: A CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO THE OFFICE AT THE EARLIEST POSSIBLE TIME.

To the best of my knowledge, the foregoing questions have been accurately answered.

Permission to release Health Information:

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and /or health practitioners.

Person completing the form : Signature_____

Print name_____

If other than patient, indicate relationship_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without financial arrangements, must be paid for in cash at the time the services are performed. Patients who carry dental insurance understand that all dental services that are furnished are charged directly to the patient and that he or she is personally responsible for payment. This office helps prepare the patients insurance forms or assist in making collect ions from insurance companies and will credit any such collections to the patients account. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. I also understand that the fee listed for this dental care can only be extended for a period of 90 days from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to the Doctor, or is assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that reasonable of said services shall be as billed unless objected to, by me, I writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have read the above conditions of treatment and agree to their content.

Signature of Patient, parent or guardian_____

Date_____

Dentists History Review & Significant Findings

_____

_____

_____

_____

_____

Doctor Signature Date

THANK YOU!