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* ( )

College Student Status: Full Time Part Time Please provide school info:

Employment Status: Full Time Part Time Retired

Marital Status: Married Single Divorced Separated Widowed

Pref. Pharmacy: Phone: ( )

School Name:__________________________________

Address:__________________________________

Address 2:__________________________________

City, State, Zip:__________________________________

Dental Insurance Information

Primary Insurance Information

Name of Insured: ______________________________

Insured Soc. Sec.: ______________________________

Employer:______________________________

Address:______________________________

Address 2:______________________________

City, State, Zip:______________________________

ID#: ________________ Gr#:________________

Relationship to Patient: Self Spouse Child Other

Insured Birth Date: ______________________________

Ins. Company: ______________________________

Address: ______________________________

Address 2: ______________________________

City, State, Zip: ______________________________

Secondary Insurance Information

Name of Insured: ______________________________

Insured Soc. Sec.: ______________________________

Employer:______________________________

Address:______________________________

Address 2:______________________________

City, State, Zip:______________________________

ID#: ________________ Gr#:________________

Relationship to Patient: Self Spouse Child Other

Insured Birth Date: ______________________________

Ins. Company: ______________________________

Address: ______________________________

Address 2: ______________________________

City, State, Zip: ______________________________

Dental Information

For the following questions, mark (X) your responses to the following questions.

	Yes	**No**	**DK**
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?			
Is your home water supply fluoridated?			
Do you drink bottled or filtered water?			
If yes, how often?			
Are you currently experiencing dental pain or discomfort?			

	Yes	**No**	**DK**
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 you Don't Know the answer to the question) **Yes No DK**

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 DK

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 taking 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?

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 hormone 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: **Yes No DK**
To all **yes** responses, specify type of reaction.

Local anesthetics ______________________
Aspirin ______________________
Penicillin or other antibiotics ______________________
Barbituates, sedatives, or sleeping pills__________________
Sulfa drugs ______________________
Codeine or other narcotics______________________
Metals______________________
Latex (rubber) ______________________
Iodine ______________________
Hay fever / seasonal ______________________
Animals ______________________
Food ______________________
Other______________________

Yes No DK	Yes No DK	Yes No DK	Yes No DK
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 . . . .
Rheumatic 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 of 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 relevent 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 reyl on this information for treating me. I acknowledge that my questions, if 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: ______________________

MISSED APPOINTMENT POLICY

At our office your scheduled appointment time is reserved just for you. We try not to overbook appointment times in order to provide excellent dental care and to be sure we have sufficient time to adequately meet your dental needs.

We make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of twenty-four (24) hours in advance if you are unable to do so. Failure to comply with this policy will neccessitate the assessment of the following fees:

First missed appointment: You will be charged a missed appointment fee of $25.00

Second missed appointment: You will be charged a missed appointment fee of $50.00

At this time, we will require payment prior to any future appointments. Further lateness or missed appointments will, unfortunately, terminate our relationship.

Please sign below that you have read and understand this policy.

Sign: **Date:**