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PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Today's Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ P.O. Box/Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Social Security #: _____

Email: _____ I would like to receive correspondence via E-mail Text

MEDICAL HISTORY:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's/specialist's care now? Yes No Explain: _____

Have you been hospitalized or had a major operation? Yes No Explain: _____

Have you ever had a serious head or neck injury? Yes No Explain: _____

Are you taking any medications, pills or drugs? Yes No Explain: _____

Have you ever taken Fosamax, Boniva, Actonel
 or any other medications containing Bisphosphonates? Yes No Explain: _____

Are you on a special diet? Yes No Explain: _____

Do you use tobacco? Yes No Explain: _____

Do you use controlled substances? Yes No Explain: _____

Do you drink alcoholic beverages? Yes No How much?: _____

WOMEN:

Are you pregnant? Yes No Trying to get pregnant? Yes No Taking Oral Contraceptives? Yes No

MEDICAL INFORMATION:

Doctor's Name: _____ Phone: _____ Email: _____

Joint Replacement:

Yes No Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
 If Yes, Date: _____ Doctor's Name: _____ Phone: _____

Were there any complications?

Yes No 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 metastatic cancer?

Date treatment began _____ Doctor's Name: _____ Phone: _____

Damaged Heart Valve &/or Replacement:

Yes No Date _____ Doctor's Name: _____ Phone: _____

Patient Name: _____ DOB: _____

Allergies: Are you allergic to any of the following?

- Yes No Local anesthetics:
- Yes No Aspirin:
- Yes No Penicillin or other antibiotics:
- Yes No Barbiturates, Sedatives, or sleeping pills:
- Yes No Sulfa Drugs:
- Yes No Codeine or other Narcotics:
- Yes No Metals:
- Yes No Latex (Rubber):
- Yes No Hay fever/Seasonal:
- Yes No Animals:
- Yes No Food:
- Yes No Other: _____

Please specify the reaction:

Do you have or have you had any of the following? (Please check all that apply and specify if necessary)

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> GE Reflux/Heartburn | <input type="checkbox"/> Persistent Swollen Glands in Neck |
| <input type="checkbox"/> Abnormal Bleeding/Bleeding Disorder | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Recurrent Infections |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heart Murmur | |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Heart Pacemaker | |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Heart Trouble/Disease | |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hemophilia | |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Hepatitis A | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis B or C | |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Herpes | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> High Cholesterol | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hives or Rash | |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hypoglycemia | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Irregular Heartbeat | |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Kidney Problems | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Leukemia | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Lung Disease | |
| <input type="checkbox"/> Damaged Heart Valves | <input type="checkbox"/> Malnutrition | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Health disorders | |
| <input type="checkbox"/> Drug Addiction | | |
| <input type="checkbox"/> Eating Disorder | | |
| <input type="checkbox"/> Emphysema | | |
| <input type="checkbox"/> Epilepsy | | |
| <input type="checkbox"/> Excessive Bleeding | | |
| <input type="checkbox"/> Frequent Cough | | |
| <input type="checkbox"/> Frequent Diarrhea | | |
| <input type="checkbox"/> Frequent Headaches | | |
| <input type="checkbox"/> Fainting Spells/Dizziness | | |
| <input type="checkbox"/> Gastrointestinal Disease | | |

Type of Infection:

- Rapid Weight Loss
- Renal Dialysis
- Rheumatic Heart Disease
- Rheumatoid Arthritis
- Scarlet Fever
- Seizures
- Sexually Transmitted Disease
- Sickle Cell Disease
- Sinus Trouble
- Sleep Disorder
- Spina Bifida
- Shingles
- Stomach/Intestinal Disease
- Stomach Ulcers
- Stroke
- Swelling in Limbs
- Systemic Lupus Erythematosus
- Thyroid Disease
- Tonsillitis
- Tuberculosis
- Tumors or Growths
- Yellow Jaundice

Specify:

- Mitral Valve Prolapse
- Migraines
- Night Sweats
- Neurological Disorders
- Osteoporosis
- Pain in Jaw Joints
- Parathyroid Disease

Have you ever had any serious illness not listed above? Yes No

If yes, please specify: _____

Patient Name: _____ DOB: _____

DENTAL INFORMATION

- Do your gums bleed when you brush or floss? Yes No
- Are your teeth sensitive to cold, hot, sweets, or pressure? Yes No
- Does food or floss catch between your teeth? Yes No
- Is your mouth dry? Yes No
- Have you had any periodontal (gum) treatments? Yes No
- Have you ever had orthodontic (braces) treatment? Yes No
- Have you had any problems associated with previous dental treatments? Yes No
- Do you have any earaches or neck pains? Yes No
- Do you have any clicking, popping or discomfort in the jaw? Yes No
- Do you clench or grind your teeth? Yes No
- Do you wear an oral appliance (retainer, nightguard)? Yes No
- Do you have sores or ulcers in your mouth? Yes No
- Do you wear dentures or partials? Yes No
- Do you participate in active recreational activities? Yes No
- Have you ever had a serious injury to your head or mouth? Yes No
- Date of last dental exam and cleaning? _____ Date of last dental x-rays? _____

SLEEP QUALITY

- Do you snore? Yes No
- Has your partner / spouse or anyone else told you that you snore and keep them from sleeping comfortably? Yes No
- Has anyone told you that you stop breathing for a few seconds while you are sleeping? Yes No
- Do you have a CPAP machine?
_____ Yes No
- Do you have sleep apnea?
_____ Yes No

Are you currently experiencing any dental pain or discomfort? Yes No

If yes, please explain: _____

What is the reason for your dental visit today? _____

SMILE EVALUATION (Please check Yes or No)

- Are you missing any teeth? Yes No
- Are the edges of any teeth worn down, chipped, uneven? Yes No
- Do any of your teeth appear too small, short, large or long? Yes No
- Do you have any prior dental work that appears unnatural? Yes No
- Do you have any crowns or bridges that appear dark at the edge of your gums? Yes No
- Do you have any gray, black or silver (mercury) fillings in your teeth? Yes No
- Do you have a "gummy" smile (too much of your gums show when smiling)? Yes No
- Are your gums red, sore, puffy, bleeding, or receded? Yes No
- Does the appearance of your smile inhibit you from laughing or smiling? Yes No
- When being photographed, do you smile with your lips closed instead of flashing a full smile? Yes No
- Are you self-conscious about your teeth or smile? Yes No
- Would you like to change anything about the appearance of your teeth or smile? Yes No

If you answered YES to ANY of the questions above, there are often several alternatives to improve your teeth and smile. You can have the smile you've always wanted!

Additional Dental Concerns: _____

DENTAL BENEFITS INFORMATION

POLICY HOLDER INFORMATION (IF NOT YOURSELF):

First Name: _____ Middle: _____ Last Name: _____ Home Tel: _____
Address: _____ P.O. Box/Apt. #: _____ Work Phone: _____ Ext: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Birth Date: _____ Social Security #: _____ Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION:

Name of Insurance: _____ Group #: _____ ID #: _____
Company Address: _____ Customer Service Phone #: _____
City: _____ State: _____ Zip: _____
Employer: _____ Employer's Phone #: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____

1. The undersigned hereby authorize the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me, and to use the appropriate medication and therapy indicated for such treatment in connection with the patient named on this form. I understand that using anesthetic agents embodies a certain risk.
3. I consent to allow the photographs taken to be used for the following: Dental Records, Dental Research, Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books as well as marketing materials including websites, printed materials, and patient education.
4. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained.
6. I authorize the use of my social security number to file my dental claims.

Signature of patient/parent/or guardian: _____ Date: _____

Please Handle Me With Care

Patient Name: _____

We feel it is necessary to develop a rapport with our patients. Many new patients have had a past unpleasant dental experience. It is crucial to us to know and understand your concerns. We are committed to taking time to get to know you, discuss your concerns, your fears, and your dental expectations.

Please place a check mark in the box next to the statement that concerns you or describes your problem.

- I gag easily.
- I feel out of control when I'm lying down for a long time.
- I feel uncomfortable about what you will say about my teeth and hygiene.
- Pain relief is a top priority for me.
- I don't like shots (or I've had a bad reaction to shots).
- Please tell me what I need to know about my mouth in order to make an informed decision.
- My teeth are very sensitive.
- I don't like the sound of that tool that makes the picking and scraping noise. It is like someone is scratching fingernails on a blackboard.
- I don't like cotton in my mouth.
- I hate the noise of the drill.
- Please respect my time, I do not want to be left sitting in the reception area.
- I want to know the cost up front.
- I have difficulty listening and remembering what I hear while sitting in the dental chair.
- I use/ or am interested in using nitrous oxide (laughing gas) for dental treatment.
- I am interested in oral sedation, for adults who need deeper state of sedation.