

# DENTAL REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

\_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2 DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
 I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date \_\_\_\_\_ Relationship to Patient

## 3 PHONE NUMBERS

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## 4 DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

# 3 HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- |  |  |                       |  |                                 |  |
|--|--|-----------------------|--|---------------------------------|--|
| AIDS/HIV   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                 |  |
|  |  | Radiation Treatment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                 |  |

Do you wear contact lenses?  Yes  No

**Women:**

Are you pregnant?  Yes  No  
 Taking birth control pills?  Yes  No

Due date \_\_\_\_\_

Are you nursing?  Yes  No

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Pharmacy Name \_\_\_\_\_  
 Phone (\_\_\_\_\_) \_\_\_\_\_

## ALLERGIES

- |  |   |
|--|---|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            |
| <input type="checkbox"/> Iodine                        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Latex                         | _____                                     |

# 6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

### Patient Acknowledgement

*Please sign this form below to acknowledge that you have today either received or reviewed a copy of our notice of privacy practices.*

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (please print)

I am also signing for my minor children: \_\_\_\_\_  
(please print names)

Date: \_\_\_\_\_

### Patient Consent

*Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.*

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (please print)

I am also signing for my minor children: \_\_\_\_\_  
I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, care giver)

\_\_\_\_\_  
(please print names)

I also give my permission for information regarding \_\_\_\_ appointments, \_\_\_\_ insurance benefits, \_\_\_\_ financial arrangements to be discussed with the above individuals, except: \_\_\_\_\_

Date: \_\_\_\_\_

### For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

\_\_\_\_\_  
An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

\_\_\_\_\_  
Office Personnel (signature)

\_\_\_\_\_  
Office Personnel (print name)

Date: \_\_\_\_\_

# PATIENT COMMUNICATION PREFERENCES

## To Our Valued Patients:

We are updating our records to determine the best way to communicate with you regarding treatment and appointments in our practice, as well as information regarding your dental health.

Please let us know your preferred method for receiving messages from us:

- Cell phone – number: \_\_\_\_\_
- Home phone – number: \_\_\_\_\_
- Work phone – number: \_\_\_\_\_
- Email: \_\_\_\_\_

In the event you cannot be reached by phone, is there someone we may leave a message with? (e.g. spouse, partner) Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

May we send text messages to you regarding your appointments? \_\_\_\_ Yes \_\_\_\_ No  
Please send text messages to (number) \_\_\_\_\_

May we send e-mail messages to you regarding your appointments? \_\_\_\_ Yes \_\_\_\_ No

In the future we may send electronic billing statements to you when applicable.  
Would you like to receive electronic statements from our practice? \_\_\_\_ Yes \_\_\_\_ No

Would you like to receive electronic newsletters from our practice? \_\_\_\_ Yes \_\_\_\_ No

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **Informed Consent for General Dental Procedures**

You, the patient have the right to accept or reject treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or option of no treatment.

Do not consent to treatment unless and until you potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, commonly known risks and potential complications are associated with dental treatment. No one can guarantee the success of recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

1. Pain, swelling, and discomfort after treatment
2. Infection in need of medication, follow-up procedures, or other treatment
3. Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, and/or tongue along with possible loss of taste
4. Damage to adjacent teeth, restorations, or gums
5. Possible deterioration of your condition which may result in tooth loss
6. The need fro replacement of restorations, implants, or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow up care and treatment, or consultation by a dental specialist
9. A root tip, bone fragment, or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop
10. Jaw fracture
11. If upper teeth are treated, a chance of a sinus infection or opening between the mouth and sinus cavity exists, which may need further treatment
12. Allergic reaction to anesthetic or medication
13. Need for follow up care and treatment including surgery

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase your chances for a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you have a heart condition or heart murmur, advise your dentist immediately so he/she can consult your physician.

The patient is an important member of the treatment team. In addition to complying with instructions given to you by this office, it is important to report any problems or complications you experience so your dentist can address them.

If you are a women on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking, antibiotics.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential risks and complications of recommended treatment with your dentist. Be certain your dentist addresses all of your concerns to your satisfaction before commencing treatment.

*Patient or Guardians Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

## MISSED APPOINTMENT & CANCELLATION POLICY

Our office reserves time aside especially for your appointment, any last minute cancellations inconveniences everyone. Therefore, we request that you kindly provide us with at least a **48** hour notice before canceling any future appointments. We often have a list of patients waiting to be scheduled and when you give us notice, we are able to accommodate others. Thank you for your understanding!

Please read the policy below and sign where indicated:

- ❖ If you need to reschedule or cancel an appointment, please give us **48 hour** notice to avoid a charge
  
- ❖ If you fail to arrive for your scheduled appointment and have not given us a **48 hour** notice, you will be charged a missed appointment fee.
  
- ❖ The charge for a missed or cancelled appointment not within **48 hours** of the scheduled appointment for professional hygiene visit is **\$25**, and for a cancelled or missed appointment with any of our doctors would be **\$50**. This is not covered by insurance plans and is your responsibility to pay.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_