# Patient Registration

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

Preferred Name:_____ Pronouns:_____

Date of Birth:_____ Gender (circle one): M F X

SSN:_____

Address:_____

City:_____ State:_____

Zip:_____

Home Phone:_____ Cellular:_____

Email:_____

**Preferred method of contact (circle one):** Text Email Phone Call

Emergency Contact:_____ Ph#:_____

Signature:_____ Date:_____

**Responsible Party (if other than self):**

Name:_____

Date of Birth:_____ Relationship:_____

Address:_____

City:_____ State:_____

Zip:_____

Ph#:_____ Email:_____

**Dental and Medical Health History**

Patient Name _____

*Welcome! Please complete both sides of this dental/ medical history form so that we may provide the best possible dental care.*

***All information is completely confidential.***

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 medication 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 care now? Yes__ No__ If yes, please explain _____
Have you ever been hospitalized or had a major operation? Yes__ No__ If yes, please explain _____
Are you taking any medications, pills or drugs? Yes__ No__ If yes, please explain _____
_____
Do you take, or have you taken, Phen-Fen or Redux? Yes__ No__ If yes, please explain _____
Have you ever taken Fosamax, Boniva, Actonel, or any
other medications containing bisphosphonates? Yes__ No__ If yes, please explain _____
Are you on a special diet? Yes__ No__ If yes, please explain _____
Do you use tobacco? Yes__ No__ If yes, please explain _____
Do you use controlled substances? Yes__ No__ If yes, please explain _____

**Women:** Are you
**Pregnant/Trying to get pregnant?** Yes__ No__ **Taking oral contraceptives?** Yes__ No__ **Nursing?** Yes__ No__

Are you allergic to any of the following?
Aspirin__ Penicillin__ Codeine__ Local Anesthetics__ Acrylic__ Metal__ Latex__ Sulfa Drugs__
Other__ If yes, please explain _____

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

| | | | |
|---|---|---|---|
| AIDS/HIV Positive | Yes__ No__ | Drug Addiction | Yes__ No__ |
| Alzheimer's Disease | Yes__ No__ | Easily Winded | Yes__ No__ |
| Anaphylaxis | Yes__ No__ | Emphysema | Yes__ No__ |
| Anemia | Yes__ No__ | Epilepsy or Seizures | Yes__ No__ |
| Angina | Yes__ No__ | Excessive Bleeding | Yes__ No__ |
| Arthritis/ Gout | Yes__ No__ | Excessive Thirst | Yes__ No__ |
| Artificial Heart Valve | Yes__ No__ | Fainting Spells/Dizziness | Yes__ No__ |
| Artificial Joint | Yes__ No__ | Frequent Cough | Yes__ No__ |
| Asthma | Yes__ No__ | Frequent Diarrhea | Yes__ No__ |
| Blood Disease | Yes__ No__ | Frequent Headaches | Yes__ No__ |
| Blood Transfusion | Yes__ No__ | Genital Herpes | Yes__ No__ |
| Breathing Problem | Yes__ No__ | Glaucoma | Yes__ No__ |
| Bruise Easily | Yes__ No__ | Hay Fever | Yes__ No__ |
| Cancer | Yes__ No__ | Heart Attack/ Failure | Yes__ No__ |
| Chemotherapy | Yes__ No__ | Heart Murmur | Yes__ No__ |
| Chest Pains | Yes__ No__ | Heart Pacemaker | Yes__ No__ |
| Cold Sores/ Fever Blisters | Yes__ No__ | Heart Trouble/ Disease | Yes__ No__ |
| Congenital Heart Disorder | Yes__ No__ | Hemophilia | Yes__ No__ |
| Convulsions | Yes__ No__ | Hepatitis A | Yes__ No__ |
| Cortisone Medicine | Yes__ No__ | Hepatitis B or C | Yes__ No__ |

| | | | |
|---|---|---|---|
| Diabetes | Yes__ No__ | Herpes | Yes__ No__ |
| High Blood Pressure | Yes__ No__ | Renal Dialysis | Yes__ No__ |
| High Cholesterol | Yes__ No__ | Rheumatic Fever | Yes__ No__ |
| Hives or Rash | Yes__ No__ | Rheumatism | Yes__ No__ |
| Hypoglycemia | Yes__ No__ | Scarlet Fever | Yes__ No__ |
| Irregular Heartbeat | Yes__ No__ | Shingles | Yes__ No__ |
| Kidney Problems | Yes__ No__ | Sickle Cell Disease | Yes__ No__ |
| Leukemia | Yes__ No__ | Sinus Trouble | Yes__ No__ |
| Liver Disease | Yes__ No__ | Spina Bifida | Yes__ No__ |
| Low Blood Pressure | Yes__ No__ | Stomach/Intestinal Disease | Yes__ No__ |
| Lung Disease | Yes__ No__ | Stroke | Yes__ No__ |
| Mitral Valve Prolapse | Yes__ No__ | Swelling of Limbs | Yes__ No__ |
| Osteoporosis | Yes__ No__ | Thyroid Disease | Yes__ No__ |
| Pain in Jaw Joints | Yes__ No__ | Tonsillitis | Yes__ No__ |
| Parathyroid Disease | Yes__ No__ | Tuberculosis | Yes__ No__ |
| Psychiatric Care | Yes__ No__ | Tumors or Growths | Yes__ No__ |
| Radiation Treatments | Yes__ No__ | Ulcers | Yes__ No__ |
| Recent Weight Loss | Yes__ No__ | Venereal Disease | Yes__ No__ |
| | | Yellow Jaundice | Yes__ No__ |

Have you ever had any serious illness not listed above? Yes__ No__
Comments:

_____
_____
_____

What is the reason for your visit today? _____
_____

Date of Last Dental Visit? _____ Last Cleaning Date? _____
Last Full Mouth X-rays? _____
What was done at your last dental visit? _____
Previous Dentist's Name _____ Telephone _____
Address _____ State _____ Zip _____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
Have you ever used or are you currently using topical fluoride? Yes __ No __
What other dental aids do you use (Interplak, toothpick, etc.)? _____
Do you have any dental problems now? Yes __ No __
If yes, please describe: _____

**Are any of your teeth sensitive to:**

| | |
|---|---|
| Hot or cold? | Yes __ No __ |
| Sweets? | Yes __ No __ |
| Biting or chewing? | Yes __ No __ |
| Have you noticed or tasted any mouth odors or bad taste? | Yes __ No __ |
| Do you frequently get cold sores, blisters or any other oral lesions? | Yes __ No __ |
| Do your gums bleed or hurt? | Yes __ No __ |
| Have your parents experienced gum disease or tooth loss? | Yes __ No __ |

Have you noticed any loose teeth or change in your bite? Yes __ No __
Does food tend to become caught in between your teeth? Yes __ No __
If yes, where? _____

**Do you:**

Clench or grind your teeth while awake or asleep? Yes __ No __
Bite your lips or cheeks regularly? Yes __ No __
Hold foreign objects with your teeth? Yes __ No __
Mouth breathe while awake or asleep? Yes __ No __
Have tired jaws especially in the morning? Yes __ No __
Snore or have any other sleeping disorders? Yes __ No __
Smoke/ chew tobacco or use other tobacco products? Yes __ No __

**Have you ever had:**

Orthodontic treatment? Yes __ No __
Oral surgery? Yes __ No __
Periodontal treatment? Yes __ No __
Your teeth ground or the bite adjusted? Yes __ No __
A bite plate or mouth guard? Yes __ No __
A serious injury to the mouth or head? Yes __ No __
If yes, please describe, including cause _____

**Have you experienced:**

Clicking or popping of the jaw? Yes __ No __
Pain (joint, ear, side of face)? Yes __ No __
Difficulty in opening or closing the mouth? Yes __ No __
Difficulty in chewing on either side of the mouth? Yes __ No __
Headaches, neck aches, or shoulder aches? Yes __ No __
Sore muscles (neck, shoulder)? Yes __ No __
Are you satisfied with your teeth's appearance? Yes __ No __
Would you like to keep all of your teeth all of your life? Yes __ No __
Do you feel nervous about having dental treatment? Yes __ No __
If so, what is your biggest concern? _____
Have you ever had an upsetting dental experience? Yes __ No __
If yes, please describe _____

Have you ever been told to take a premedication prior to dental treatment? Yes __ No __

Is there anything else about having dental treatment that you would like us to know? Yes __ No __
If yes, please describe_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE_____

# Dental Office Financial Agreement

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

**General:** Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

**Missed Appointments:** Unless we receive notice of cancellation 48 hours in advance, you will be charged $75.00. Please help us service you better by keeping scheduled appointments.

**Insurance:** Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. *It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.* If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

**Payment:** FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT COPAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

**Unpaid balances over 30 days old will be subject to monthly interest of 1.5% (APR 18%).** If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

**By signing this Financial Agreement, I acknowledge that I have read, understand and agree to the terms and conditions of this Financial Agreement.**

**Signature:**_____ **Date:**_____

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