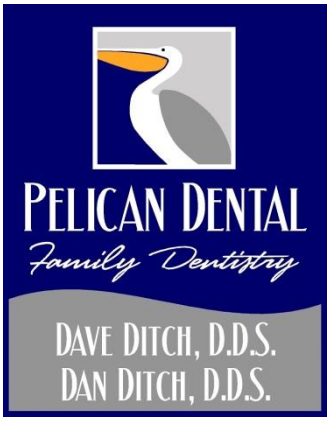
Patient Registration Information



Patient Name (Last, First, MI)

Preferred Name **Birth Date:** (MM/DD/YYYY)

Gender: **Marital Status:**

Address Line 1:

Address Line 2:

City: **State:** **Zip Code:**

Home Phone: **Work Phone:** **Mobile Phone:**

( ) -	( ) -	( ) -

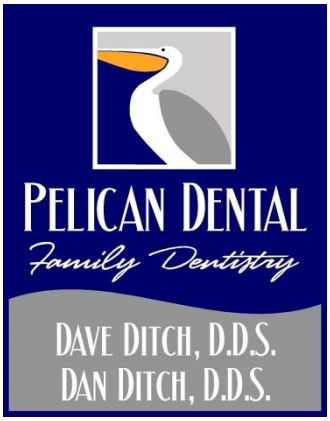
Email:

Patient SSN: **Patient Employer/School:** **Occupation:**

Person Responsible for Account: **Relationship to Patient:** **How did you hear about us?**

Emergency Contact Name: **Relationship to Patient:** **Emergency Contact Phone #**

Dental History



Former Dentist – Name and City

When did you last visit a dentist?

What do you feel is the present condition of your mouth?

Do your gums bleed? If so, when and where?

Have you ever been told you have gum disease?

Does food chronically collect between your teeth? If so, where?

Are your teeth acutely sensitive to any of the following? (circle each that apply)

Sweets	Cold	Heat	Pressure	No

How often do you brush your teeth? **How often do you floss your teeth?**

Are you happy with the appearance of your smile? (Yes or No – please explain)

Appointment Communication:

Best time/day to schedule an appointment:

How would you prefer your appointment communication to be confirmed? (please circle preferences)

Home phone #	Cell phone #	Email	Text

Phone #:

Please circle correct carrier:

Sprint	AT&T	TMobile	Verizon	Other

Email:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received/reviewed a copy of this office's Notice of Privacy Practices.

Patient Name:	**Date:**

Patient or Legal Guardian Signature:	**Relation to Patient:**

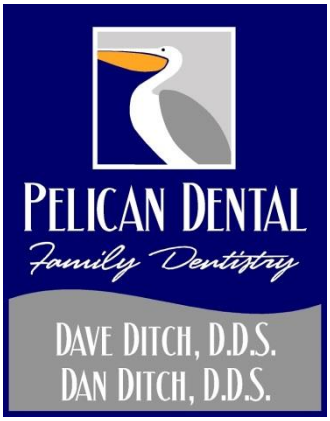
I give, _____ consent to access my protected

health information, to carry out treatment, payment activities and health care operations.

X_____ **_____**

Signed (Patient OR guardian if a minor) **Date**

Insurance Signature on File Form



- I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance benefits.
- I authorize release of any information relating to my dental claims.

X_____ _____

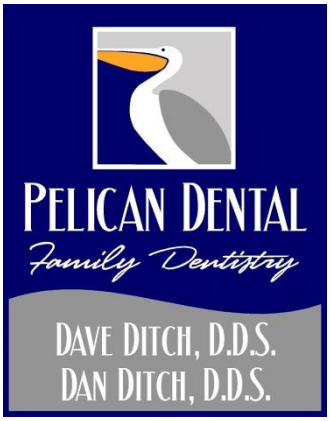
Signed (Patient OR guardian if a minor) **Date**

- I assign dental benefit payments to be paid directly to Pelican Dental from my insurance company.

X_____ _____

Signed (Patient OR Insured Person) **Date**

Medical History



Are you presently taking any medications/drugs/pills/supplements?

Yes	No

If yes please list, including dosages, or offer a list of your medications for scanning in your chart: _____

_____

_____

_____

_____

Name of your medical clinic: _____

Example: Essentia, Lake Region HealthCare, Sanford, VA

When was your last medical physical? _____

Are you under the care of a physician at this time?

Yes	No

Allergies: (please circle)

Penicillin	Codeine	Local Anesthetic	Latex	Jewelry	None

Other Allergies: _____

Are you pregnant?

Yes	No

If yes, when is your expected delivery date? _____

PLEASE CIRCLE ANY OR ALL THAT APPLY:

Heart Condition:

Congenital Heart Defect	Rheumatic Fever	Murmur	Surgery
Murmur	Surgery	Pacemaker	

Other Heart Conditions: _____

_____

_____

PLEASE CIRCLE ANY OR ALL THAT APPLY:

Joint Replacement: | Knee | Hip |

Date of Surgery: _____

Other Joint Replacements:

_____

_____

_____

Do you require a premedication prior to dental treatment? | Yes | No |

If so, list the drug, dosage, time of administration and who prescribed/advised so?

_____

_____

_____

Blood Thinners: | Coumadin | Warfarin |

Other Blood Thinners: _____

High Blood Pressure	**Diabetes**	**Thyroid Condition**	**Sinus Problems**
Fainting Spells	**Epilepsy**	**Asthma**	**Cancer/Chemo/Radiation**
Hepatitis (Type)____	**Ulcers**	**Acid Reflux**	**HIV Positive/AIDS**

Any other condition/concern not previously specified?

_____

_____

_____

_____

Sleep Apnea Screening

1) Do you experience any of the following problems? (circle all that apply)

Daytime Sleepiness	Unrefreshing Sleep	Fatigue	Insomia

2) Do you ever wake from sleep with a choking sound or gasping for breath? Yes No

3) Has anyone noticed that you snore or stop breathing while you sleep? Yes No

4) Do you have any of the following symptoms? (circle all that apply)

Nocturia (waking at night to use the bathroom)	Morning Headaches	Memory Loss
Difficulty Concentrating	Decreased Sexual Desire	Irritability

5) Do you have any of these physical features? (circle all that apply)

Obesity - Body Mass Index (BMI) of 30 or higher	Large Neck Size - 17 in. or greater for men/16 in. or great for women	Enlarged Tongue/Tonsils
Recessed Jaw	Nasal Polyps	Deviated Septum

6) Do you have any of these other medical problems that are common in people with sleep apnea? (circle all that apply)

High Blood Pressure	Mood Disorders	Coronary Artery Disease	Stroke
Congestive Heart Failure	Atrial Fibrillation	Heart Attack	Type 2 Diabetes

I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any supplemental information, are true and complete to the best of my knowledge and belief.

X_____ _____

Signed (Patient OR guardian if a minor) **Date**