

Patient Registration Information



Patient Name (Last, First, MI)

Preferred Name

Birthdate: (MM/DD/YYYY)

____/____/____

Gender:

Marital Status:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Home Phone:

(____) _____ - _____

Work Phone:

(____) _____ - _____

Cellphone:

(____) _____ - _____

Email:

Patient SSN:

Patient Employer/School:

Occupation:

Person Responsible for Account:

Relation to Patient:

Emergency Contact Name:

Relation to Patient:

Emergency Contact Phone #

How did you hear about us?

Dental History

Previous Dentist – Name and City

--	--

When was the last time you visited the 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 before you have gum disease?

--

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

--

Are you teeth 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 be confirmed? (please circle)

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.

Signature _____ Date: _____



Dental Insurance Co. and Policy #

(Please offer your insurance card for scanning)

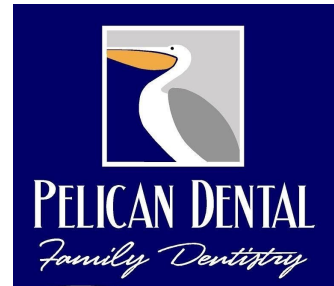
I hereby authorize payment of the Group Insurance Benefits payable directly to the below named dentist, otherwise payable to:

Signed: _____

I accept this attending dentist's statement and authorize release of information relating hereto. I certify the truth of all personal information contained above. I agree to be responsible for payment for services provided during any ineligible period.

Patient Signature: _____

Medical History



Are you presently taking any medications, drugs, pills, or supplements? Yes No (please circle)

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

Name of your medical clinic: _____

When was your last medical physical? _____

Are you under the care of a physician at this time? Yes No (please circle)

Allergies: (please circle)

Penicillin	Codeine	Local Anesthetic	Latex	Jewelry	None
------------	---------	------------------	-------	---------	------

Other Allergies: _____

Are you pregnant? Yes No (please circle)

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 Other

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: (please circle)

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?

Do you have a health care directive you would like on file with us? Yes No (please circle)

Patient Signature: _____

Date: _____

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.

Sleep Apnea Screening

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

Daytime Sleepiness	Unrefreshing Sleep	Fatigue	Insomnia
--------------------	--------------------	---------	----------

Yes	No
-----	----

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?

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.

Patient Signature: _____

Date: _____