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: _____