

Step 1 - Patient Registration - Personal Information:

First, Last _____ Male Female
 Home Address _____
 City _____ State _____ Zip _____
 Birthdate _____ Married Single
 Home Phone # _____ Cell # _____ Work Phone # _____
 E-mail Address _____ Medicaid # _____ Soc. Sec. # _____
 I am a full time student School Name _____
 Occupation _____
 Referred by _____ Visit Reason _____

Emergency information (A relative NOT living with you):

Name _____ Phone # _____
 Relationship To Guarantor (Person Responsible For Account)
 Primary is Self Spouse Child Parent Other Preferred Provider _____

Step 2 - Patient Registration - Responsible Party Information:

Add this patient member to an existing guarantor

Guarantor Information (Person Responsible For Account)

First, Last _____
 Address _____
 City _____ State _____ Zip _____ Birthdate _____
 Home Phone # _____ Work Phone # _____ E-mail _____
 Soc. Sec. # _____ Driver's Lic. _____
 Coverage Cash Single Ins. / PPO Dual Insurance Pre-paid/Capitation Medicaid

Step 3 - Patient Registration & Health History:**Primary Insurance Information**

Add New Carrier Select Existing Carrier
 Carrier ID _____
 Insurance Co. Name _____
 Insurance Co. Address _____
 City _____ State _____ Zip _____ Phone # _____
 Group/Plan # _____ Union Local # _____
 Eligibility Phone # _____

Primary Employer Information

Add New Employer Select Existing Employer
 Employer ID _____
 Employer Name _____
 Employer Address _____
 City _____ State _____ Zip _____ Phone # _____

Step 4 - Patient Health History - Dental

Dental History Information

Previous Dentist Name _____

City _____ Phone # _____

How LONG SINCE you have seen a dentist? _____

Last COMPLETE dental exam date _____

Last FULL MOUTH X-RAYS date _____

Are you having PROBLEMS now? Yes No

If yes, please explain:

Do you wear DENTURES? (Partials or Full) Yes No

Are you unhappy with your dentures? Yes No

Have you any PERIODONTAL (GUM) treatments? Yes No

Do your gums BLEED, or feel TENDER, or IRRITATED? Yes No

Are your teeth SENSITIVE to hot, cold, sweets, or pressure? Yes No

Are you UNHAPPY with the appearance of your teeth? Yes No

Are you aware of GRINDING or CLENCHING your teeth? Yes No

Do you have HEADACHES, EARACHES, or NECK PAINS? Yes No

Do you have LOOSE, TIPPED or SHIFTING teeth? Yes No

Have you worn BRACES on your teeth? (ORTHODONTICS) Yes No

Do you have DISCOLORED teeth that bother you? Yes No

Would you like your smile to LOOK BETTER or DIFFERENT? Yes No

Do you have problems with teeth/fillings BREAKING? Yes No

Do you REGULARLY use DENTAL FLOSS? Yes No

Are you aware of being ALLERGIC TO or reacting adversely to any medications or substances?

Yes No

If yes, please list:

Step 5 - Patient Health History - Medical

Medical History Information

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: _____
- Have you ever had a serious head or neck injury? 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 _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

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 Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

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

- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | Hive or Rash <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Recent Weight loss <input type="radio"/> Yes <input type="radio"/> No | |

Additional Comments

PLEASE GIVE 48 HOUR NOTICE FOR RESCHEDULING AN APPOINTMENT TO AVOID A \$100 CANCELLATION FEE

Authorization and Release (please sign after printing)

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (or parent/guardian if minor)

Date