PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU, START HERE.

DATE			
LAST NAME	FIRST		MI
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		WORK NO.	
CELL PHONE NO.		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD, START HERE.

DATE			
LAST NAME	FIRST		MI
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX.

GETTING TO KNOW YOU

PERSON TO CONTACT FOR EMERGENCY	RELATIONSHIP
HOME PHONE NO.	
PHARMACY NAME	PHONE NO.

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

SECONDARY CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

HAVE YOU OR A CLOSE FAMILY MEMBER BEEN SEEN AT OUR OFFICE IN THE PAST?

YES	NO
IF YES, WHAT IS THEIR NAME?	

1. I hereby authorize doctor or designated staff to take x-rays, cone beam ct-scan, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (patient name)_____'s dental needs. I understand that if a cone beam ct-scan is taken, I have the option to have the scan forwarded to a board-certified oral and maxillofacial radiologist* for a complete reading of any presence of pathology in the medically related anatomical structures which may be seen in the images and data. I understand that should I opt not to have my cone beam ct-scan reviewed by a board-certified oral and maxillofacial radiologist, medical conditions beyond the scope of dentistry may not be diagnosed.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, other medications, and the application of the time release antibiotic (Arestin) as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I understand that if for any reason I am unable to keep my scheduled appointment(s), I am required to make any appointment changes at least 48 hours in advance. I understand that failure to provide 48 hours advance notice may result in a $25.00 failed appointment fee that will be due prior to my next appointment. I understand that missed or cancelled appointments could result in the need for additional periodontal or implant treatment and expenses.
5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. 1-1 ½ % late charge (18% APR) may be added to my account for all unpaid balances.

CONSENT FOR TREATMENT

Patient/Responsible Party_____Date_____Witness_____

*Additional fees may apply.

PATIENT NAME	HOW SHOULD WE ADDRESS YOU?
MEDICAL ALERT	

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name: _____ Phone: _____
   Address: _____ City: _____ State: _____ Zip: _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs, or pills now? ..... Yes No
   If yes, please list name and dosage _____
   _____
4. Have you ever taken/do you take bisphosphonates (ie Fosamax)? ..... Yes No
5. Are you aware of having any allergic (or adverse) reaction to any medication or substance?
6. If yes, please list: _____
7. Have you been a patient in the hospital during the past five years? ..... Yes No
8. Indicate which of the following you have had, or have at the present. **Circle "Yes" or "No" to each item.**

Heart (Surgery, Disease, Attack)	Yes No	Ulcers	Yes No	Hepatitis	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	A.I.D.S.	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	H.I.V. Positive	Yes No
High Blood Pressure	Yes No	Contact Lenses	Yes No	Cold Sores/Fever Blisters	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Blood Transfusion	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Sickle Cell Disease	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Hay Fever	Yes No	Liver Disease	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Yellow Jaundice	Yes No
Swollen Ankles	Yes No	Allergies or Hives	Yes No	Neurological Disorders	Yes No
Stroke	Yes No	Sinus Trouble	Yes No	Epilepsy or Seizures	Yes No
Diet (Special/Restricted)	Yes No	Radiation Therapy	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joints (hip, knee, ect)	Yes No	Chemotherapy	Yes No	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Tumors	Yes No	Psychiatric/Psychological Care	Yes No

1. Are you currently taking any of the following? **Circle "Yes" or "No" to each item.**

Flax	Yes No	Garlic	Yes No	Energy Drinks	Yes No
Krill Oil	Yes No	Ginger	Yes No	Aspirin	Yes No
Vitamin E	Yes No	Ginseng	Yes No	Ibuprofen	Yes No
Ginkgo	Yes No	Green Tea	Yes No	Glucosamine	Yes No
				Fish Oil	Yes No

2. Do you smoke? If so, how much? ..... Yes No
3. Have you had abnormal bleeding associated with extractions, surgery, injury or menstruation? ..... Yes No
4. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
5. **Women:** Are you: **Pregnant?** Yes,_____ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

D.D.S. Signature: _____ **Date** _____