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610-865-6999

PATIENT REGISTRATION

Single Married Widowed Divorced

____
Last Name First Name Middle Initial

Address ____
Street City State Zip

Home Phone # ____________ Cell Phone # ____________ Work Phone # ____________

Date of Birth ____________ Social Security Number ____________

Person responsible for Acount ____________ Relationship ____________

In Case of Emergency Contact ______________________________
Name Phone #

Your Email: ____________ Who may we thank for referring you? ____________

DENTAL HISTORY

Reason for dental treatment ______________________________

Have you ever had a problem associated with previous dental treatment? YES _______ NO _______

If YES, please explain ______________________________

Does dental treatment make you nervous? NO _______ SLIGHTLY _______ MODERATELY _______ EXTREMELY _______

When was the last time you were seen by a dentist? ______________________________

Previous dentist ______________________________
Name Address

Did your previous dentist take any dental x-rays of your teeth? YES _______ NO _______

Have you sustained any injuries to the head, neck mouth or teeth? YES _______ NO _______

Do you have or have you had any of the following conditions:

Bleeding or Sore Gums	YES _______	NO _______	Loose Teeth	YES _______	NO _______
Unpleasant Taste	YES _______	NO _______	Sensitivity to:		
Bad Breath	YES _______	NO _______	Hot	YES _______	NO _______
Burning Tongue/Lips	YES _______	NO _______	Cold	YES _______	NO _______
Frequent Blisters	YES _______	NO _______	Sweets	YES _______	NO _______
Swelling or Lumps	YES _______	NO _______	Chewing	YES _______	NO _______
Orthodontic Treatment	YES _______	NO _______	Food Impaction	YES _______	NO _______
Biting Cheeks/Lips	YES _______	NO _______	Clenching	YES _______	NO _______
Jaw Clicking or Popping	YES _______	NO _______	Grinding	YES _______	NO _______
Difficulty Opening/ Closing Jaw	YES _______	NO _______	Change in Bite	YES _______	No _______
			Finger/Thumb Sucking	YES _______	NO _______

Do you do any of the following:

Brush	YES _______	NO _______	How often do you brush? ____________
Floss	YES _______	NO _______	How often do you floss? ____________
Fluoride	YES _______	NO _______	Do you take a fluoride supplement? YES _______ NO _______

What type of toothbrush do you use? HARD _______ MEDIUM _______ SOFT _______

MEDICAL HISTORY

Physician ____________________________________ Phone Number __________________________ City __________________________

Date of last Physical Examination ____ Blood Pressure ______________________________

Are you in Good Health? YES _______ NO _______ Are you Under the Care of a Physician? YES _______ NO _______

For what condition? ____

Do you have any disease or problem not listed that you think we should know about? YES _______ NO _______ If yes, please explain _____

____

Have you been hospitalized or had an operation? YES _______ NO _______ If so, please list ______________________________________

____

Have you been advised to undergo any medical treatment / operation for which you haven't? YES _______ NO _______ If yes, what? _____

____

Do you have any physical or mental disabilities? YES _______ NO _______ If yes, what? ____

Do you have a prosthetic joint? YES _______ NO _______ If so, where? ____

Do you have a heart murmur? YES _______ NO _______

Do you have a heart valve replacement? YES _______ NO _______ If so, when? ____

Do you take an antibiotic before dental treatment? YES _______ NO _______ If so, what and how many? _____________________________

____

Medication List:

____

____

Allergies: Circle any of the following which you have had an allergic or adverse reaction to…

PENICILLIN ERYTHROMYCIN AMOXICILLIN CODEINE SULFA DRUGS ASPIRIN ADVIL TYLENOL

NOVOCAINE NITROUS OXIDE

Are you Allergic to any other Medications or Substances? YES _______ NO _______ If so, please list ________________________________

____

Are you pregnant? YES _______ NO _______ If yes, due date? ____________________________

Are you taking birth control ? YES ________ NO _______ Are you on hormone Therapy? YES _______ NO _______

Do you use tobacco in any form? YES _______ NO _______ If yes, how and how much? ____

Do you use alcohol beverages (more than 2 drinks per day)? YES _______ NO _______ If yes, how many? ____________________________

Medical Conditions: Have you had or do you currently have…

	YES	NO		YES	NO		YES	NO
Heart Murmur			**Sinus Problems**			**Thyroid Problems**		
Heart Attack			**Kidney Problems**			**Ulcers**		
Heart Surgery			**Frequent Headaches**			**Stomach/Intestional Proble**		
Mitral Valve Prolapse			**Seizures**			**Colitis**		
Congenital Heart Defect			**Epilepsy**			**Arthritis**		
Artificial Heart Valve			**Nervous / Psych Problems**			**Artificial Bones**		
Pacemaker			**Tumors/ Growths**					
Rheumatic Fever			**Cancer**					
Angina Pectoris			**Chemotherapy**					
High Blood Pressure			**Radiation**					
Low Blood Pressure			**Liver Disease**					
Abnormal Bleeding			**Yellow Jaundice**					
Hemophilia			**Hepatitis A**					
Anemia			**Hepatitis B**					
Sickle Cell Disease			**Alcohol Abuse/ Use**					
Stroke			**Drug Abuse/ Use**					
Fainting Spells			**Venereal Disease**					
Difficulty Breathing			**HIV/ AIDS**					
Asthma			**Fever Blisters/ Herpes**					
Emphysema			**Shingles**					
Tuberculosis			**Diabetes**					
Hay Fever			**Glaucoma**					

Patient Signature: ____ **Date** _________________________

Reviewed By: Dr. ____ **Date** _________________________

Employer ____

Occupation ____

Dental Insurance? Yes ______ No ______ If yes, complete next section.

INSURANCE INFORMATION

Name of Insurance Company ______________________________Phone Number ______________

Address ____

Subscriber's Name ______________________________ Date of Birth ______________

Relationship to Subscriber ______________________ Social Security Number ______________

Subscriber's Employer ______________________ Group or Policy Number ______________

Is patient covered by additional insurance? YES _______ No _______ If yes, please complete information

Name of Secondary Insurance Company ______________________ Phone Number ______________

Address ____

Subscriber's Name ______________________________ Date of Birth ______________

Relationship to Subscriber ______________________ Social Security # ______________

Subscriber's Employer ______________________ Group or Policy Number ______________

I understand that my dental benefits are based upon a contract between my insurance carrier and myself. I am responsible for payment, regardless of insurance coverage, for dental services provided in this office for myself or my dependants, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received within 60 days from the date of service a 1 ½% finance charge (18% APR) will be added to my account. I further understand that I am responsible for those fees incurred for delinquency and / or any other insufficiency (e.g.- those incurred by a collection agency, magistrate office, or an attorney).

Patient / (or Guardian) Signature ______________________________ date ______________

PATIENTS WITHOUT INSURANCE

I understand that I am fully responsible for all dental fees and that these fees are due and payable at the time services are rendered; unless a prior financing arrangement has been made. In the event payments are not received within 60 days from the date of service, in accordance with said financial arrangements, a 1 ½% finance charge (18% APR) will be added to my account. I further understand that I am responsible for those fees incurred for delinquency and / or any other insufficiency (e.g.- those incurred by a collection agency, magistrate office, or an attorney).

Patient / (or Guardian) Signature ______________________________ date ______________

CONSENT FOR TREATMENT

I, the undersigned, certify that the information on these pages is correct and accurate. I hereby authorize any treatment necessary, related to the dental care of the patient whose name appears on this history form and grant authority to administer anesthetics, analgesics and to perform such procedures, deemed necessary or advisable in the diagnosis and treatment of this patient. I understand that there are possible adverse effects of the procedure, anesthetics and / or drugs to be employed.

Patient / (or Guardian) Signature ______________________________ date ______________