

welcome

PATIENT NUMBER

Date _____

Patient's Name _____ Date of Birth _____ Male Female

If Child: Parent's Name _____

How do you wish to be addressed _____ Single Married Separated Divorced Widowed Minor

Residence - Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment Insurance Cash Credit Card

Purpose of Call _____

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

Dental Insurance 1st Coverage

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

Dental Insurance 2nd Coverage

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any Information concerning my (or my child's) health care, advice and treatment to another dentist

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carder or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in pad by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIAN'S SIGNATURE

DATE _____

REGISTRATION



Patient number grid

PATIENT NUMBER

Patient's Name _____ First _____ Initial _____ Date of Birth _____

- 1. Purpose of initial visit
2. Are you aware of a problem?
3. How long since your last dental visit?
4. What was done at that time?
5. Previous dentist's name
6. When was the last time your teeth were cleaned?

COMMENTS

Large empty box for patient comments

- CLICK THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW ON THE LINE AFTER THE QUESTION.
7. Have you made regular visits?
8. Were dental x-rays taken?
9. Have you lost any teeth or have any teeth been removed?
10. Have they been replaced?
11. How have they been replaced?
12. Are you unhappy with the replacement?
13. Would you like to know about permanent replacements?
14. Have you ever had any problems or complications with previous dental treatment?
15. Do you clench or grind your teeth?
16. Does your jaw click or pop?
17. Have you experienced any pain or soreness in the muscles or your face or around your ear?
18. Do you have frequent headaches, neckaches or shoulder aches?
19. Does food get caught in your teeth?
20. Are any of your teeth sensitive to:
21. Do your gums bleed or hurt?
22. How often do you brush your teeth?
23. Do you use dental floss?
24. Are any of your teeth loose, tipped, shifted or chipped?
25. Are you unhappy with the appearance of your teeth?
26. How do you feel about your teeth in general?
27. Do you feel your breath is offensive at times?
28. Have you ever had gum treatment or surgery?
29. Have you had any orthodontic work?
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
31. Do you have any questions or concerns?

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST. box

MED.ALERT box

DENTAL HISTORY



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PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW ON THE LINE AFTER THE QUESTION"

COMMENTS

1. Physician's Name _____
Address _____
City _____ State _____ Zip _____ Tel _____
2. Are you under a physician's care? _____ YES NO
Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? _____ YES NO
(if yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? _____ YES NO
6. Are you allergic to any medications or substances? (please list) _____ YES NO
7. Do you have any other allergies or hives? _____ YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? _____ YES NO
9. Are you sensitive to any metals or latex? _____ YES NO
10. Are you pregnant or suspect you may be? _____ YES NO
11. Do you use any birth control medications? _____ YES NO
12. Have you ever been treated for or been told you might have heart disease? _____ YES NO
13. Do you have a pacemaker or an artificial heart valve implant? _____ YES NO
14. Have you ever had rheumatic fever? _____ YES NO
15. Are you aware of any heart murmurs? _____ YES NO
16. Do you have high or low blood pressure? (please circle) _____ YES NO
17. Have you ever had a serious illness or major surgery? _____ YES NO
If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? _____ YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? _____ YES NO
20. Do you have any artificial joints/prosthesis? _____ YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc? _____ YES NO
22. Have you ever bled excessively after being cut or injured? _____ YES NO
23. Do you have any stomach problems? _____ YES NO
24. Do you have any kidney problems? _____ YES NO
25. Do you have any liver problems? _____ YES NO
26. Are you diabetic? _____ YES NO
27. Do you have fainting or dizzy spells? _____ YES NO
28. Do you have asthma? _____ YES NO
29. Do you have epilepsy or seizure disorders? _____ YES NO
30. Do you or have you had venereal disease? _____ YES NO
31. Have you tested HIV positive? _____ YES NO
32. Do you have AIDS? _____ YES NO
33. Have you had or do you test positive for hepatitis? _____ YES NO
34. Do you or have you had T.B.? _____ YES NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? _____ YES NO
36. Do you consume alcoholic beverages? _____ YES NO
37. Do you habitually use controlled substances? _____ YES NO
38. Have you had psychiatric treatment? _____ YES NO
39. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? _____ YES NO
40. Do you have any disease condition, or problem not listed? If so, explain _____

41. Is there anything else we should know about your health that we have not covered in this form? _____
42. Would you like to speak to the Doctor privately about any problem? _____ YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED.ALERT

MEDICAL HISTORY

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PATIENT NUMBER

welcome

Patient's Name _____
Last First Initial Nickname Date of Birth
Parents's Guardian's Name _____

DENTAL HISTORY - CHECK THE APPROPRIATE ANSWER

- 1. Is this your child's first visit to a dentist? YES NO
- 2. If not, how long since the last visit to the dentist? _____
- 3. Were any x-rays or radiographs taken when your child previously visited the dentist? YES NO
- 4. Does your child eat between meals? YES NO
- 5. Does your child eat sweets, such as candy, soda pop, chewing gum? YES NO
- 6. When does your child brush his/her teeth?
 Upon arising After eating any food Right after meals Before going to bed
- 7. How does your child receive Fluoride?
 Community water level _____ ppm Well water level _____ ppm
 Fluoride drops or tablets Fluoride rinse or gel
- 8. Have any cavities been noted in the past? YES NO
- 9. Were any teeth (baby or permanent) removed by extraction? YES NO
Was it suggested that the space be maintained ... YES NO
Was an appliance placed YES NO
- 10. Have there been any injuries to teeth, such as falls, blows, chips, etc? YES NO
If so describe _____
- 11. Has your child had any problem with dental treatment in the past? YES NO
- 12. Has anyone in the family, including parents, had orthodontics? YES NO
- 13. Has your child ever received a local anesthetic? YES NO
- 14. Has your child ever had occlusal sealants? YES NO
- 15. Does your child think there is anything wrong with his/her teeth? YES NO

COMMENTS

MEDICAL HISTORY

- 1. Does your child have a health problem? YES NO
- 2. Is your child under the care of physician? YES NO
If yes, since when and why? _____
- 3. Name of physician _____ phone _____
- 4. Is your child receiving any medication? YES NO
What? _____
- 5. Is your child allergic to penicillin, antibiotics or other drugs?..... YES NO
- 6. Is your child allergic to or sensitive to any metals or latex?..... YES NO
- 7. Does your child have other allergies? YES NO
- 8. Has your child had any serious illness? YES NO
When _____ What _____
- 9. Has your child ever had surgery? YES NO
- 10. Does your child have a heart murmur? YES NO
- 11. Is surgery contemplated? YES NO
- 12. Does your child experience severe or prolonged bleeding? YES NO
- 13. Does your child have AIDS or has he/she tested HIV positive? YES NO
- 14. Has your child tested positive for hepatitis? YES NO
- 15. Is your child subject to nervous disorders? YES NO
 Fainting? Seizures? Dizziness? Behavioral/Learning problems?
- 16. Does your child have frequent headaches? YES NO
- 17. Has your child had history of: (Check appropriate responses)
 Diabetes Cerebral palsy Infections
 Head trouble Liver problems Speech impairments
 Asthma Congenital birth defects Hearing loss
 Kidney infection Mental retardation
 Rheumatic fever Eyesight problems
 Epilepsy Cancer

/ CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE,

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____
DENTISTS SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

CHILD DENTAL MEDICAL HISTORY

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PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial Date of Birth

I hereby authorize _____
DOCTOR'S NAME

and whomever he/she may designate as his/her assistants, to perform upon me the following operation and/or procedures:

I request and authorize him/her to do whatever he/she deems advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling, in their **judgment, for procedures** in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatments and the consequences if this treatment were withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

Patient or Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

Witness's Signature _____ Date _____

CONSENT FORM

Insert Name of Practice]

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number-_____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name-_____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

Describe the reason why the individual would not sign this form: _____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

**ACKNOWLEDGEMENT OF RECEIPT OF
PRIVACY PRACTICES NOTICE**