

Patient Registration and Insurance Information



PATIENT INFORMATION

Name: _____
Age: _____ Date of Birth: _____ SS#: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell Phone #: _____
Employer: _____
Occupation: _____ Work Phone #: _____

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber Name: _____
Member ID#: _____ Subscriber Date of Birth: _____
Employer: _____
Dental Insurance Name: _____
Insurance Address: _____
Insurance Phone #: _____ Group #: _____

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber Name: _____
Member ID#: _____ Subscriber Date of Birth: _____
Employer: _____
Dental Insurance Name: _____
Insurance Address: _____
Insurance Phone #: _____ Group #: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to the named provider of the group insurance benefits otherwise payable to me.

Patient's Signature: _____ Date: _____

RELEASE OF INFORMATION

I authorize the release of information necessary to process the claim.

Patient's Signature: _____ Date: _____

Patient Medical History

Patient Name: _____

Date of Birth: _____

Referring Doctor and Location: _____



Indicate which of the following conditions you currently have or have had in the past. By checking the box it will indicate a “YES” response, leaving blank will indicate a “NO” response.

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Aspiration/Choking Risk |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> Bell's Palsy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> COPD | <input type="checkbox"/> CPAP User |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Lupus - Connective Tissue | <input type="checkbox"/> Cognitive Disability | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Easily Winded |
| <input type="checkbox"/> Strong Gag Reflex | <input type="checkbox"/> Currently/Possibly Pregnant or Nursing | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Osteoporosis Medication History | <input type="checkbox"/> HIV | <input type="checkbox"/> Heart Valve Replacement |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Immunosuppressed |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Head and Neck Injuries | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Raynaud's Syndrome | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Nicotine Use - Current |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nicotine Use - Former |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Nicotine Use - Smoker |
| <input type="checkbox"/> Cannabis Use | <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Nicotine Use - Smokeless Tobacco |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Nicotine Use - Vaping |
| <input type="checkbox"/> Dental Phobia | <input type="checkbox"/> Substance Use | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Sjogren's Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Tuberculosis | | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Vision Problems | | <input type="checkbox"/> Cancer or History of Cancer
Type: _____ |
| | | <input type="checkbox"/> No Medical Conditions or Concerns |

Patient Medical History Continued

Please explain/clarify any conditions or alerts previously selected:



Conditions/Alerts: (If none, please write none or N/A)

Allergies (Please list all): (If none, please write none or N/A)

Do you take antibiotic premedication for your dental visits? If yes, please explain below:

Name of your primary Physician and Phone Number:

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Are you currently taking any medications (prescription or non-prescription) including regular doses of aspirin? If yes, please list all medications and reason for being prescribed:

- *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my signature.**

Dental History



What is your immediate concern or reason for referral?

Referring Dentist's Name and Phone Number:

Date of most recent dental exam, dental cleaning, deep cleaning, or dental x-rays:

Check all that apply:

- Complications from past dental treatment
- Excessive bleeding
- Difficulty with anesthesia either getting or staying numb
- Adverse reactions to local anesthetic
- Had/have braces, orthodontic treatment
- Dry Mouth (Xerostomia)
- Experience teeth sensitive to cold, hot, biting, sweets, or brushing
- Food becomes trapped between teeth
- Jaw joint problems (pain, popping, clicking)
- Frequent headaches
- Sores or lumps in your mouth
- Head, neck or jaw injuries
- Difficulty chewing
- Clenching or grinding of your teeth
- Currently wear or have worn a bite guard appliance
- Gums bleed when brushing or flossing
- Treated for gum disease or were told you have lost bone around teeth
- Noticed an unpleasant taste or odor in your mouth
- Receding gums
- Had any teeth become loose on their own (without injury)
- Experienced a burning sensation in your mouth
- Experience snoring, sleep apnea, insomnia, trouble falling asleep
- Have had scaling and root planing (deep cleaning)
- None

If any of the checked boxes need further explanation, please describe:

Patient Privacy and Contact Information



I wish to be contacted in the following manner (CHECK ALL THAT APPLY):

Home Phone #: _____

- OK to leave message with detailed information
- Leave message with call back number ONLY

Cell Phone #: _____

- OK to leave message with detailed information
- Leave message with call back number ONLY

Work Phone #: _____

- OK to leave message with detailed information
- Leave message with call back number ONLY

E-mail address: _____

Emergency contact:

Phone #:

My information may be released to:

General Dentist(s)/Dental Specialist(s): _____

Medical Doctor(s): _____

Other:

Relationship

I confirm that the above information is correct and I have received the Notice of Privacy Practices.

Patient's Name (PRINT): _____

Patient's Signature: _____ Date: _____