# PATIENT REGISTRATION

**PATIENT'S NAME:** ______________________________________________ **DATE:** __________

## 1) PATIENT'S INFORMATION:

Birth Date: ____________________ SSN: ____________________ Driver's License: ______________

Sex: O Male O Female Marital Status: O Single O Married O Divorced O Widowed

Address: ______________________________________________________________________

______________________________________________________________________

Tel: Home__________________ Work __________________ Cell __________________

Email:________________________________ □ Yes, I would like to receive correspondences via email

Emergency Contact: ____________________________________ Tel: ______________

Student status: O Full time O Part time School Name:__________________ City:____________

Employment status: O Full time O Part time O Retired

Job position: ______________________________ Employer: ______________________________

How do you like to be addressed: O First Name O Last Name O Other: ______________________

Prefer appointments on: □ Weekdays □ Saturday □ Or more specific: ______________________

**Prefer to be contacted via**: □ Phone**:** __*home* __*cell* __*work* □ Email □ Other: ______________

Do you need language assistance provided by your insurance plan? O No O Yes, language:______________

**How did you hear about us**? __________________________ Previous dentist: ______________

## 2) RESPONSIBLE PARTY (if someone other than the patient):

Name: ______________________________________________________________________

Birth Date: ____________________ SSN: ____________________ Driver's License: ______________

Address (*if different from* 1): ______________________________________________________

Tel (*if different from* 1): Home__________________ Work ______________ Cell ______________

O Responsible Party is also a Policy Holder for Patient

O Primary Insurance Policy Holder O Secondary Insurance Policy Holder

If **your child** is the patient, please tell us:

Parent's Marital Status: O Single O Married O Divorced O Widowed

Who is responsible for making appointments? ____________________________________________

Tel (*if different from* 1): Home__________________ Work ______________ Cell______________

## 3) PRIMARY INSURANCE INFORMATION: O Premier/Pay-per-service O PPO/DPO O HMO O Other

Name of Subscriber:____________________________________________________________

Relationship to Patient: O Self O Spouse O Parent O Other ______________

Insured SSN (*if different from* 1 or 2): __________________ Insured Birth Date: ______________________

Subscriber ID: ____________________________________ Group ID: ______________________

Employer: ________________________________ Insurance Company: ______________________

## 4) SECONDARY INSURANCE INFORMATION: O Premier/Pay-per-service O PPO/DPO O HMO O Other

Name of Subscriber: ____________________________________________________________

Relationship to Patient: O Self O Spouse O Parent O Other ______________

Insured SSN: ______________________________ Insured Birth Date: ______________________

Subscriber ID: ____________________________________ Group ID: ______________________

Employer: ________________________________ Insurance Company: ______________________

# MEDICAL HISTORY

*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 special care now? O Yes O No If yes, please explain: ________________________
Your physician's name: ____________________ Clinic:____________________Phone:_______________________

Have you ever been hospitalized or had a major operation? O Yes O No

| WHEN DID THE OPERATION(S) TAKE PLACE? | REASON(S) |
|---|---|
| | |

Have you ever had a serious injury to head, neck and mouth? O Yes O No If yes, please explain: ________________________________
Are you taking any medications, pills, or drugs? O Yes O No

| CURRENT MEDICATION(S) | SINCE WHEN? | REASON(S) |
|---|---|---|
| | | |

Are you using oral Biphosphonates (Fosamax, Actonel, Boniva, etc.) for osteoporosis? O Yes O No
Are you on a special diet? O Yes O No If yes, please explain:________________________________
Do you use tobacco? O Yes O No If yes, how much and since when?______________________
Do you use controlled substances? O Yes O No If yes, how much and since when?______________________
Do you drink alcohol? O Yes O No If yes, how much and since when?______________________

**Are you allergic to any of the following?**
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal
☐ Latex ☐ Local anesthetics ☐ Sulfa
☐ Other ________________________________

**FOR WOMEN:**
Pregnant? ☐ Yes Taking oral contraceptives? ☐ Yes
Months of pregnancy: ____
Nursing? ☐ Yes

Please checkmark the boxes below if you have, or have had, one or more of the following:

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

**Have you ever had any serious illness not listed above?** O Yes O No
If yes, please explain: ________________________________________________________________

Doctor Signature: ____________________________________________ Date: ________________

# DENTAL HISTORY

**PATIENT'S NAME:** ______________________________________

What is your main reason for seeking dental care today? ________________________________________
When was your last dental exam and cleaning? ______________________________________________
How often do you see your dentist? _____________________________________________________

Describe any previous problems you have had with past dental treatments or special areas of concern you would like to have addressed by Wellness Dental Care: ________________________________________________

Are you happy with your smile? O Yes O No
If no, what do you like us to do to improve your smile? __________________________________________

Please checkmark the boxes below if you have one or more of the following?

- ☐ Grinding/clenching teeth
- ☐ Cheek biting (during speech or eating)
- ☐ Tongue thrust (abnormal swallowing)
- ☐ Mouth breathing
- ☐ Gag easily
- ☐ Bad breath
- ☐ Dry mouth
- ☐ Pain around ears
- ☐ Joint popping (or unusual noises during eating)
- ☐ Joint pain
- ☐ Difficulty in chewing
- ☐ Chewing on one side
- ☐ Other: _____________________________________________________

How often do you brush? _________________________
How often do you floss? _________________________

| Are your teeth sensitive to | | | |
|---|---|---|---|
| Hot or cold? | O Present | O Past | O Never |
| Biting/Chewing? | O Present | O Past | O Never |
| Sweets? | O Present | O Past | O Never |

| Have you ever had any of the following? | | | |
|---|---|---|---|
| Braces/Orthodontic treatment | O Present | O Past | O Never |
| TMD treatment | O Present | O Past | O Never |
| Gum surgery/Periodontal treatment | O Present | O Past | O Never |
| Biopsy/Oral cancer treatment | O Present | O Past | O Never |

**Over…**

# GENERAL CONSENT TO DENTAL TREATMENT

By signing at the bottom of the page, I acknowledge that I have received the **Acknowledgement of Receipt of Notice of Privacy Practices, Dental Materials Fact Sheet and Consent – Signature on File,** and I agree to have the following treatment(s) if recommended by the dentist:

**- Examination**
**- Dental x-rays** (I shall inform the staff in advance if I am pregnant)
**- Medications** and **local anesthesia** (shots) if required.

*I understand that antibiotics, analgesics, and other medications may cause bad reactions, some of which are, but not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, and cardiac arrest (heart stops). I understand that medications, drugs, and anesthesia may cause drowsiness and lack of coordination. I understand that, occasionally, when a local anesthetic is injected, I may have prolonged, persistent anesthesia, numbness, and/or irritation to the area of injection.*

**- Hygienic care and treatment for Periodontics** (Tissue and Bone Loss)

*I understand that the long-term success of dental treatments depends on maintaining good oral hygiene on a daily basis. I fully understand the attendant risks and complications that may arise and jeopardize my dental and general health due to my decision not to take the recommended treatment or necessary referral if I am diagnosed with a moderate to advanced case of periodontal diseases.*

**- Restorations** (silver or tooth-colored fillings)

*I have been advised of the need for fillings to replace tooth structure that may be lost to decay or breakage. I understand that over time fillings will need to be replaced due to wearing of materials. In cases where very little tooth structure remains, or existing tooth breaks off, I may need to receive more extensive treatment or extractions. Also, depending on the extent of an existing decay, I may feel sensitive to hot and cold after a restoration has been placed, which can fade over time or intensify into severe pulpal complications that may require further treatments (root canals, etc.)*

I understand that all dental treatments have associated risks, which may be, but are not limited to: post-operative bruising, swelling, sensitivity or pain; post-operative infection; post-operative bleeding; tissue damages from biting while still feeling numb; fracture or loss of a filling, veneer, or crown that may require replacement; complications during treatment necessitating referral to a specialist.

I further understand that no guarantee or assurance has been given that the proposed treatment will be curative and/or successful or completed to my complete satisfaction. I agree to cooperate completely with the recommendations of the dentist while I am under his/her care. I understand that failure to follow the dentist's recommendation could result in less than optimum results.

To the best of my knowledge, **all questions from page 1 to page 4** have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in the patient's information listed in this registration form.

I give my consent to perform the treatment as described by the dentist, and I have been informed of and accept consequences if no treatment is provided.

**Patient/Guardian's Signature: ______________________________________________ Date: ____________**