REGISTRATION

PATIENT INFORMATION (CONFIDENTIAL)

NAME: _____ DATE: _____
FIRST MI LAST

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

E-MAIL: _____ CELL PHONE: _____ HOME PHONE: _____

SS#/SIN: _____ BIRTHDATE: _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

IF COLLEGE STUDENT, F.T/P.T., NAME OS SCHOOL: _____ CITY: _____ STATE: _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER: _____ WORK PHONE: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SPOUSE OR PARENT'S/GUARDIANS NAME: _____ EMPLOYER: _____ WORK PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTANCT IN CASE OF AN EMERGENCY: _____ PHONE: _____

RESPONSIBLY PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____ RELASIONSHIP TO PATIENT: _____

ADDRESS: _____ HOME PHONE: _____

DRIVER'S LICENSE #: _____ BIRTHDATE: _____ SS#/SSI: _____

EMPLOYER: _____ WORK PHONE: _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SS#/SIN: _____ DATE EMPLYED: _____

NAME OF EMPLOYER: _____ UNION OR LOCAL #: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE CO.: _____ TEL. #: _____ GRP #: _____ POLICY/I.D. #: _____

INS. CO. ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SS#/SIN: _____ DATE EMPLYED: _____

NAME OF EMPLOYER: _____ UNION OR LOCAL #: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE CO.: _____ TEL. #: _____ GRP #: _____ POLICY/I.D. #: _____

INS. CO. ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

HEALTH HISTORY

PATIENT MEDICAL HISTORY

PATIENT'S NAME: _____ DATE OF BIRTH: _____

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 THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

Gender: ☐ M ☐ F Are you currently under a physician's care: ☐ YES ☐ NO

Date of last physician visit: _____ Reason: _____

Physician Name: _____ Physician Phone #: _____

Physician Address: _____ City: _____ State: _____ Zip Code: _____

Yes	No	D/K	
☐	☐	☐	Have there been any changes in your general health in the last year?
			Have you had any serious illness, operations, or been hospitalized in the past 5 years?
☐	☐	☐	Reason: _____
☐	☐	☐	Has your physician recommended that you take antibiotics prior to dental treatment:
☐	☐	☐	Have you had an orthopedic total joint replacement? When?: _____
☐	☐	☐	Do you have a heart murmur or a history of rheumatic heart disease?
			Have you taken Pondimin (Fenfluramine), Redux (Dexphenfluramine) or Fen-Phen (Phentermine)?
☐	☐	☐	If "Yes", how long? _____
			Have you taken Fosamax (Alendronate), Actonel (Risedronate), or Bonvia (Ibandronate):
☐	☐	☐	If "Yes", how long? _____
☐	☐	☐	Have you taken cortisone (Steroids) in the last 30 days?
☐	☐	☐	Do you drink any type of alcohol daily? Type/Amount: _____ # of Years: _____
☐	☐	☐	Do you use recreational (street) drugs? _____
☐	☐	☐	Have you been treated for chemical or alcohol dependency? _____
☐	☐	☐	Do you use Tobacco? Amount: _____ # of Years: _____

Allergies

Are you allergic to any of the following?

Yes	No	D/K	
☐	☐	☐	Local anesthetic (e.g. Novocaine)
☐	☐	☐	Penicillin/antibiotics
☐	☐	☐	Barbiturates
☐	☐	☐	Sulfa drugs
☐	☐	☐	Codeine or other narcotics
☐	☐	☐	Aspirin
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Latex
☐	☐	☐	Nickel (jewelry, clothing snaps)
☐	☐	☐	Acrylic

Type of reaction: _____

Other Allergies: _____

Females Only:

Yes	No	D/K	
☐	☐	☐	Post-menopausal or post-hysterectomy
☐	☐	☐	Are you pregnant? Due date: _____
☐	☐	☐	Are you currently breast feeding?
☐	☐	☐	Are you currently taking birth control medication? Why type? : _____

DENTAL HISTORY

Chief Complaint:

_____

_____

_____

Are you receiving routine dental care? ☐ Yes ☐ No

If Yes, Dentist Name: _____

Date of last dental visit: _____

Reason for last dental visit: _____

How often did you visit your previous dentist? _____

Have you had a complete series of dental films (x-rays)

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Have any of the following prevented your from seeking dental care?

- ☐ Fear or anxiety
- ☐ Lack of time
- ☐ Lack of funds/cost
- ☐ No insurance
- ☐ No transportation
- ☐ Other:

Indicate any past major dental treatment (check all that apply)

- ☐ Orthodontics (braces)
- ☐ Oral surgery (extractions)
- ☐ Periodontics (gum treatment or surgery)
- ☐ Endodontics (root canal)
- ☐ Partial dentures
- ☐ Full dentures
- ☐ Crowns
- ☐ Bridges
- ☐ TMJ

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

_____

Yes	No	Are your teeth sensitive to:
☐	☐	Sweets
☐	☐	Hot
☐	☐	Cold
☐	☐	Pressure (chewing)

Have you ever had problems/complications with past dental care?

☐ Yes ☐ No

Specify:

_____

_____

Yes	No	Please check all that apply:
☐	☐	Do you have any swelling in your mouth?
☐	☐	Are you teeth shifting?
☐	☐	Are any of your teeth loose?
☐	☐	Do you have any food impaction between teeth?
☐	☐	Are you aware of any loose, broken or missing fillings, or chipped teeth?

Do you drink fluoridated drinking water?

☐ Yes ☐ No ☐ D/K

Dentures

How long worn? _____

Age of present dentures? _____

How many past dentures? _____

Any current problems? _____

Salivary Function

Yes	No	
☐	☐	Does your saliva feel think or ropey?
☐	☐	Does your mouth feel dry?
☐	☐	Do you have difficulty chewing food?
☐	☐	Do you have difficulty speaking?
☐	☐	Do you have excess saliva?

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date:_____

Signature of patient or parent/guardian if minor

Doctor's comments: _____

_____

_____

Signature: _____ Date: _____

SYSTEMS REVIEW-CHECK ALL THAT APPLY

Patient Name: _____ Patient DOB: _____

Yes No D/K

☐ ☐ ☐ **1.CARDIOVASCULAR CONDITIONS**
- ☐ Angina
- ☐ Atherosclerosis date: _____
- ☐ Artificial heart valve date: _____
- ☐ Internal defibrillator
- ☐ Heart attack date: _____
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Congenital heart defects
- ☐ Mitral valve prolapse
- ☐ Bypass surgery date: _____
- ☐ Pacemaker date: _____
- ☐ Tire easily
- ☐ Chest pain, shortness of breath or

Yes No D/K

☐ ☐ ☐ **2. RESPIRATORY CONDITIONS**
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Asthma
- ☐ Seasonal allergies
- ☐ Sinusitis
- ☐ Tonsil or adenoid conditions

Yes No D/K

☐ ☐ ☐ **3. GASTROINTESTINAL CONDITIONS**
- ☐ Colon disorders
- ☐ Persistent diarrhea
- ☐ Difficulty swallowing
- ☐ Gastroesophageal reflux
- ☐ Ulcers
- ☐ Malnutrition
- ☐ Jaundice
- ☐ Gallbladder trouble/stones
- ☐ Liver disease
- ☐ Hepatitis A B C
- ☐ Cirrhosis
- ☐ Other liver conditions

Yes No D/K

☐ ☐ ☐ **4. ENDOCRINE CONDITIONS**
- ☐ Thyroid problems _____
- ☐ Parathyroid problems _____
- ☐ Diabetes Type: _____
- ☐ Hypoglycemia

Yes No D/K

☐ ☐ ☐ **5. GENITOURINARY CONDITIONS**
- ☐ Kidney problems
- ☐ Dialysis
- ☐ Bladder infections

Yes No D/K

☐ ☐ ☐ **6. SEXUALLY TRANSMITTED DISEASED**

Type: _____

Yes No D/K

☐ ☐ ☐ **7. CANCER**

Site: _____
- ☐ Surgery Date:
- ☐ Chemotherapy Date: _____
- ☐ Radiation therapy Site: _____

Yes No D/K

☐ ☐ ☐ **8. BONE & JOINT CONDITIONS**
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Trauma/Frequent fractures
- ☐ TMJ problems
- ☐ Jaw surgery

Yes NO D/K

☐ ☐ ☐ **9. BLEEDING ABNORMALITIES**
- ☐ Prolonged bleeding
- ☐ Bruise easily
- ☐ Anemia
- ☐ Sickle cell disease _____
  Trait _____
- ☐ Hemophilia Type: _____
- ☐ Blood transfusion Year: _____

Yes No D/K

☐ ☐ ☐ **10. NEUROLOGIC CONDITIONS**
- ☐ Epilepsy
- ☐ Convulsions/seizures
- ☐ Stroke
- ☐ Neuritis
- ☐ Neuralgia/Tics
- ☐ Chronic facial pain
- ☐ Numbness/Paralysis
- ☐ Severe frequent headaches
- ☐ Migraines
- ☐ Repeated blackouts/fainting

Yes No D/K

☐ ☐ ☐ **11. PSYCHOLOGICAL TREATMENT**
- ☐ Depression
- ☐ Anxiety or panic disorders
- ☐ Eating disorders
- ☐ Other psychological disorders

Yes No D/K

☐ ☐ ☐ **12. DERMATOLOGICAL CONDITIONS**
- ☐ Chronic/recurrent skin rash
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Other: _____

Yes No D/K

☐ ☐ ☐ **13. IMMUNE CONDITIONS**
- ☐ AIDS or HIV infection
- ☐ Rheumatoid arthritis
- ☐ Immunosuppressive
  - ☐ disease induced
  - ☐ drug induced
  - ☐ induced
- ☐ Specific immune disease: _____

Yes No D/K

☐ ☐ ☐ **14. OTHER**
- ☐ Domestic violence victim
- ☐ Glaucoma
- ☐ Organ/Tissue transplant
- ☐ Night sweats
- ☐ Unintended weight loss
- ☐ Chronic pain Site: _____

CURRENT MEDICATIONS
(Including Prescribed, Over-the-Counter, and Herbal or Natural)

Patient Name: ____ Date: ______________________

Medication	Dose	Reason

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H.I.P.A.A Acknowledgement

I have received a copy of the H.I.P.A.A Privacy Act information from Dental on Central, and authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to the office.

Name: ______________________________ Date of Birth: ____________ Phone Number: ________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _________________

Name: ______________________________ Date of Birth: ____________ Phone Number: ________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _________________

Name: ______________________________ Date of Birth: ____________ Phone Number: ________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _________________

Name: ______________________________ Date of Birth: ____________ Phone Number: ________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _________________

Name: ______________________________ Date of Birth: ____________ Phone Number: ________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _________________

Name: ______________________________ Date of Birth: ____________ Phone Number: ________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _________________

Name: ______________________________ Date of Birth: ____________ Phone Number: ________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _________________

May we leave messages on your answering machine? ☐ Yes ☐ No

Signed: ____ Date: ________________________
(Patient or parent/legal guardian)

DENTAL ON CENTRAL

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LEGAL GUARDIAN CONTACT INFORMATION		
First & Last Name:	Relation/Title:	
Address:	City, State:	Zip Code:
Telephone Number:	Cell Phone Number:	

CAREGIVER CONTACT INFORMATION		
First & Last Name:	Relation/Title:	
Address:	City, State:	Address:
Telephone Number:	Cell Phone Number:	

EMERGENCY CONTACT		
First & Last Name:	Relation/Title:	
Address:	City, State:	Address:
Telephone Number:	Cell Phone Number:	
First & Last Name:	Relation/Title:	
Address:	City, State:	Address:
Telephone Number:	Cell Phone Number:	
First & Last Name:	Relation/Title:	
Address:	City, State:	Address:
Telephone Number:	Cell Phone Number:	
First & Last Name:	Relation/Title:	
Address:	City, State:	Address:
Telephone Number:	Cell Phone Number:	