PATIENT REGISTRATION

First Name: _____ Last Name: _____ ID: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Patient Information

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Birth Date: _____ Age: _____ Social Security No: _____ Drivers License: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Birth Date: _____ Age: _____ Social Security No: _____ Drivers License: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Social Security No: _____ Insured Birth Date: _____

Insurance Company: _____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Phone: _____

Website: _____

Employer: _____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Phone: _____

Website: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Social Security No: _____ Insured Birth Date: _____

Insurance Company: _____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Phone: _____

Website: _____

Employer: _____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Phone: _____

Website: _____

Comments (for office use only):

MEDICAL HISTORY

PATIENT NAME: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 care now? ◯ Yes ◯ No ◯ N/A _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No ◯ N/A _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No ◯ N/A _____

Are you taking any medications, pills or drugs? ◯ Yes ◯ No ◯ N/A _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ◯ N/A

Do you use tobacco? ◯ Yes ◯ No ◯ N/A

Are you on a special diet? ◯ Yes ◯ No ◯ N/A

Do you use controlled substances? ◯ Yes ◯ No ◯ N/A

Women: Are you ☐ Pregnant / Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Latex ☐ Codeine ☐ Acrylic ☐ Metal ☐ Penicillin ☐ Local Anesthetics ☐ Others _____

Do you have, or have you had, any of the following? (check only boxes that apply)

☐ AIDS	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsilitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problems	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Spells/Dizziness	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice
☐	☐ Cough	☐	☐	☐

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ◯ N/A _____

Comments: _____

_____

_____

* Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form 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 medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

GENERAL DENTISTRY INFORMED CONSENT FORM

NAME _____ PATIENT # _____

1. **TREATMENT TO BE DONE:**
I understand I am having the following treatment: Fillings ____, Bridges ____, Crowns ____, Cleanings ____, Extractions ____, Root Canals ____, Teeth Whitening (Zoom) ____, Other _____. (Initials _____)

2. **DRUGS AND MEDICATIONS:**
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials _____)

3. **CHANGES IN TREATMENT PLAN:**
I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials _____)

4. **REMOVAL OF TEETH:**
Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.), and I authorize the Dentist to remove the recommended teeth and any others necessary due to a change in treatment plan. I understand removing teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days, months, or in rare cases, permanently) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials _____)

5. **CROWNS, BRIDGES AND CAPS:**
I understand sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand I may be wearing temporary crowns, which may come off easily, and I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown bridge or cap (including shape, fit, size and color) will be before cementation. I understand if I do not return for my scheduled appointment for delivery of my crown, bridge, or cap, it may not fit properly, and I will be responsible for any lab fees incurred if a remake becomes necessary. (Initials _____)

6. **DENTURES - COMPLETE OR PARTIAL:**
I realize full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the “teeth in wax” try-in visit. I understand most dentures require relining approximately three to six months after initial placement and yearly thereafter. The cost for the relines is not included in the initial denture fee. (Initials _____)

7. **ENDODONTIC TREATMENT (ROOT CANAL):**
I realize there is no guarantee that root canal therapy will save my tooth, and complications can occur (such as pain or infection) from the treatment. I further realize that occasionally root canal filling material my extend through the root or it may not be possible to completely fill the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials _____)

8. **PERIODONTAL LOSS (TISSUE & BONE):**
I understand that I have a serious condition and my Dentist has advised me to have a consultation with the Periodontist. I understand that not undertaking periodontal treatment may have an adverse effect on my periodontal condition and could lead to the loss of some or all of my teeth. (Initials _____)

I understand that dentistry is not an exact science and that therefore, practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

Signature _____ Date: _____

Doctor: _____ Witness: _____