# PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

Preferred Name:

**Patient Information:**

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone:

Cell Phone:

□ I would like to receive text correspondences □ I do NOT want to receive text correspondences

Sex: ○ Female ○ Male Birth date: Social Security #:

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed ○ Partnered ○ Minor

Spouse's Name (If Applicable):

E-mail:

□ I would like to receive email correspondences □ I do NOT want to receive email correspondences

**Patient Information (section 2):**

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time ○ N/A

Patient Employer/School: Occupation:

Employer/School Address:

Employer/School Phone Number:

Whom may we thank for referring you?

**Responsible Party:** (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security #:

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household)

Name: Relationship: Phone Number:

**Patient Name:**

## PATIENT INSURANCE INFORMATION

****Does the patient have dental insurance? _____ If yes, please fill out information below.**

**Primary Insurance Information:**

| | |
|---|---|
| Policyholder's Name: | Relationship to Patient: ○Self ○Spouse ○Child ○ Other |
| Patient ID #: | Group #: |
| Policyholder's Social Security #: | Policyholder's Date of Birth: |
| Policyholder's Employer: | Insurance Company: |
| Address: | Address: |
| Address 2: | City, State, Zip: |
| City, State, Zip: | Insurance Provider Phone Number: |

**Secondary Insurance Information:**

| | |
|---|---|
| Policyholder's Name: | Relationship to Patient: ○Self ○Spouse ○Child ○ Other |
| Patient ID #: | Group #: |
| Policyholder's Social Security #: | Policyholder's Date of Birth: |
| Policyholder's Employer: | Insurance Company: |
| Address: | Address: |
| Address 2: | City, State, Zip: |
| City, State, Zip: | Insurance Provider Phone Number: |

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Prince Frederick Dental Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dental office and its dentists may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Whether dental insurance is involved or not involved, by signing below, I am acknowledging that I am responsible for any and all balances on this account.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____ Relationship to Patient _____

Patient Name:

## DENTAL QUESTIONNAIRE

Reason for today's visit:

How do you feel about your smile?

Former Dentist:

City/State: Phone Number:

Date of last dental visit:

Date of last dental x-rays:

How often do you floss?

How often do you brush?

*For the following questions, please circle your responses to the following questions.*

| | | | |
|---|---|---|---|
| Do your gums bleed when you brush or floss? | Yes | No | DK |
| Are your teeth sensitive to cold, hot, sweets or pressure? | Yes | No | DK |
| Does food or floss catch between your teeth? | Yes | No | DK |
| Do you experience dry mouth? | Yes | No | DK |
| Have you had any periodontal (gum) treatments? | Yes | No | DK |
| Have you ever had orthodontic (braces) treatment? | Yes | No | DK |
| Have you had any problems associated with previous dental treatment? | Yes | No | DK |
| Are you currently experiencing dental pain or discomfort? | Yes | No | DK |
| Do you experience bad breath? | Yes | No | DK |
| Do you have burning sensation on the tongue? | Yes | No | DK |
| Do you brux or grind your teeth? | Yes | No | DK |
| Do you have any clicking or popping in your jaw? | Yes | No | DK |
| Do you wear dentures or partials? | Yes | No | DK |
| Do you participate in active recreational activities? | Yes | No | DK |
| Have you ever had a serious injury to your head or mouth? | Yes | No | DK |
| Do you bite your fingernails? | Yes | No | DK |
| Do you have any loose teeth or broken fillings? | Yes | No | DK |
| Are your gums swollen or tender? | Yes | No | DK |

# Medical History Form(Copy)

Patient Name: Birth Date: Date Created:

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 care now? | ○ Yes ○ No | If yes |
| Have you ever been hospitalized or had a major operation? | ○ Yes ○ No | If yes |
| Have you ever had a serious head or neck injury? | ○ Yes ○ No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | ○ Yes ○ No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | ○ Yes ○ No | If yes |
| Are you on a special diet? | ○ Yes ○ No | |
| Do you use tobacco? | ○ Yes ○ No | |

Please list all current medications, pills, or drugs you are currently taking

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Barbiturates
☐ Iodine ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

| | | |
|---|---|---|
| Other allergies not listed above? | ○ Yes ○ No | If yes |
| Do you use controlled substances? | ○ Yes ○ No | If yes |

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ○ Yes ○ No | Cortisone Medicine | ○ Yes ○ No | Hemophilia | ○ Yes ○ No | Radiation Treatments | ○ Yes ○ No |
| Alzheimer's Disease | ○ Yes ○ No | Diabetes | ○ Yes ○ No | Hepatitis A | ○ Yes ○ No | Recent Weight Loss | ○ Yes ○ No |
| Anaphylaxis | ○ Yes ○ No | Chemical Dependency | ○ Yes ○ No | Hepatitis B or C | ○ Yes ○ No | Renal Dialysis | ○ Yes ○ No |
| Anemia | ○ Yes ○ No | Easily Winded | ○ Yes ○ No | Herpes | ○ Yes ○ No | Rheumatic Fever | ○ Yes ○ No |
| Angina | ○ Yes ○ No | Emphysema | ○ Yes ○ No | High Blood Pressure | ○ Yes ○ No | Rheumatism | ○ Yes ○ No |
| Arthritis/Gout | ○ Yes ○ No | Epilepsy or Seizures | ○ Yes ○ No | High Cholesterol | ○ Yes ○ No | Scarlet Fever | ○ Yes ○ No |
| Artificial Heart Valve | ○ Yes ○ No | Abnormal Bleeding | ○ Yes ○ No | Hives or Rash | ○ Yes ○ No | Shingles | ○ Yes ○ No |
| Artificial Joint | ○ Yes ○ No | Excessive Thirst | ○ Yes ○ No | Hypoglycemia | ○ Yes ○ No | Sickle Cell Disease | ○ Yes ○ No |
| Asthma | ○ Yes ○ No | Fainting Spells/Dizziness | ○ Yes ○ No | Irregular Heartbeat | ○ Yes ○ No | Sinus Trouble | ○ Yes ○ No |
| Blood Disease | ○ Yes ○ No | Cough, persistent or bloody | ○ Yes ○ No | Kidney Problems | ○ Yes ○ No | Spina Bifida | ○ Yes ○ No |
| Blood Transfusion | ○ Yes ○ No | Frequent Diarrhea | ○ Yes ○ No | Leukemia | ○ Yes ○ No | Stomach/Intestinal Disease | ○ Yes ○ No |
| Breathing Problems | ○ Yes ○ No | Frequent Headaches | ○ Yes ○ No | Liver Disease | ○ Yes ○ No | Stroke | ○ Yes ○ No |
| Bruise Easily | ○ Yes ○ No | Low Blood Pressure | ○ Yes ○ No | Swelling of Limbs | ○ Yes ○ No | Cancer | ○ Yes ○ No |
| Glaucoma | ○ Yes ○ No | Lung Disease | ○ Yes ○ No | Thyroid Problems | ○ Yes ○ No | Chemotherapy | ○ Yes ○ No |
| Infective Endocarditis | ○ Yes ○ No | Mitral Valve Prolapse | ○ Yes ○ No | Tonsillitis | ○ Yes ○ No | Chest Pains | ○ Yes ○ No |
| Heart Attack/Failure | ○ Yes ○ No | Osteoporosis | ○ Yes ○ No | Tuberculosis | ○ Yes ○ No | Cold Sores/Fever Blisters | ○ Yes ○ No |
| Heart Murmur | ○ Yes ○ No | Pain in Jaw Joints | ○ Yes ○ No | Tumors or Growths | ○ Yes ○ No | Congenital Heart Disorder | ○ Yes ○ No |
| Heart Pacemaker | ○ Yes ○ No | Parathyroid Disease | ○ Yes ○ No | Ulcers | ○ Yes ○ No | Convulsions | ○ Yes ○ No |
| Heart Trouble/Disease | ○ Yes ○ No | Psychiatric Care | ○ Yes ○ No | Venereal Disease | ○ Yes ○ No | Back Problems | ○ Yes ○ No |
| Nervous Problems | ○ Yes ○ No | Special Diet | ○ Yes ○ No | Swollen Neck Glands | ○ Yes ○ No | Sleep Apnea | ○ Yes ○ No |

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Other Comments:

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:

X Date:_____