Prince Frederick Dental Center

Patient Registration

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient Information | Section One

Address: _____ Address: 2 _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ ☐ I would like want to receive text correspondences

☐ I **DO NOT** want to receive text correspondences

Birth Date: _____ Sex: ☐ Male ☐ Female

Social Security Number _____

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

Spouse's Name (if applicable): _____

Email Address: _____

☐ I would like to receive email correspondences ☐ I **DO NOT** want to receive email correspondences

Patient Information | Section Two

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

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

Patient Employer or School: _____ Occupation: _____

Employer or School Address: _____

Employer or School Phone Number: _____

Whom may we thank for referring you to us? _____

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 Number: _____

Relationship to Patient _____

IN CASE OF EMERGENCY CONTACT (Please specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Prince Frederick Dental Center

Patient Name _____

Patient Insurance Information

****Does the patient have dental insurance?** ☐ **Yes** ☐ **No**

If yes, please fill out the information below.

Primary Insurance Information

Policy Holder's Name: _____

Address: _____ Address: 2 _____

City: _____ State: _____ Zip: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patient ID #: _____ Group # _____

Policyholder's Social Security #: _____ Policy Holder's Date of Birth: _____

Policyholder's Employer _____

Insurance Company: _____

Address: _____ Provider Phone Number: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Information

Policy Holder's Name: _____

Address: _____ Address: 2 _____

City: _____ State: _____ Zip: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patient ID #: _____ Group # _____

Policyholder's Social Security #: _____ Policy Holder's Date of Birth: _____

Policyholder's Employer _____

Insurance Company: _____

Address: _____ Provider Phone Number: _____

City: _____ State: _____ Zip: _____

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: _____

Relationship to Patient: _____ Date _____

Prince Frederick Dental Center

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? _____

Do your gums bleed when you brush or floss?	☐ YES	☐ NO	☐ NOT SURE
Are your teeth sensitive to cold, hot, sweets or pressure?	☐ YES	☐ NO	☐ NOT SURE
Does food or floss catch between your teeth?	☐ YES	☐ NO	☐ NOT SURE
Do you experience dry mouth?	☐ YES	☐ NO	☐ NOT SURE
Have you had any periodontal (gum) treatments?	☐ YES	☐ NO	☐ NOT SURE
Have you ever had orthodontic (braces) treatment?	☐ YES	☐ NO	☐ NOT SURE
Have you had any problems associated with previous dental treatment?	☐ YES	☐ NO	☐ NOT SURE
Are you currently experiencing dental pain or discomfort?	☐ YES	☐ NO	☐ NOT SURE
Do you experience bad breath?	☐ YES	☐ NO	☐ NOT SURE
Do you have burning sensation on the tongue?	☐ YES	☐ NO	☐ NOT SURE
Do you brux or grind your teeth?	☐ YES	☐ NO	☐ NOT SURE
Do you have any clicking or popping in your jaw?	☐ YES	☐ NO	☐ NOT SURE
Do you wear dentures or partials?	☐ YES	☐ NO	☐ NOT SURE
Do you participate in active recreational activities?	☐ YES	☐ NO	☐ NOT SURE
Have you ever had a serious injury to your head or mouth?	☐ YES	☐ NO	☐ NOT SURE
Do you bite your fingernails?	☐ YES	☐ NO	☐ NOT SURE
Do you have any loose teeth or broken fillings?	☐ YES	☐ NO	☐ NOT SURE
Are your gums swollen or tender?	☐ YES	☐ NO	☐ NOT SURE

Prince Frederick Dental Center

Medical History Form | Part One

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 medicaiton that you may be taking, could have an important interrelationship with the denistry 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 medication containing bisphosphonates? ☐ YES ☐ NO If yes _____

Are you on a special diet? ☐ YES ☐ NO If yes _____

Do you use tobacco? ☐ YES ☐ NO If yes _____

Please list all current medications, pills, or drugs you are currently taking: (use a separate sheet if necessary)

_____

_____

_____

_____

Women are you:

Pregnant/Trying to get pregnant ☐ YES ☐ NO

Nursing? ☐ YES ☐ NO

Taking Oral Contraceptives? ☐ YES ☐ NO

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 _____

Prince Frederick Dental Center

Medical History Form | Part Two

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

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

Have you 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: _____

Print Name_____ Date _____