

# 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

## 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 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 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?

- |                                  |                                     |                                      |  |
|----------------------------------|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine     | <input type="checkbox"/> Barbiturates      |
| <input type="checkbox"/> Iodine  | <input type="checkbox"/> Latex      | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> 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	Hemophilia	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 \_\_\_\_\_

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

Prince Frederick Dental Center  
230 West Dares Beach Road  
Prince Frederick, MD 20678  
(410) 535-5055

Patient Name: \_\_\_\_\_

**MISSED APPOINTMENT /LATE CANCELLATION POLICY**

We feel the doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the same courtesy. We understand that unforeseen circumstances do occur and ask that you advise the office if you will be unable to keep your scheduled appointment. As all appointments are reserved exclusively for you, please see our missed/cancelled appointment guidelines below.

**Late arrival:** When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive more than 10 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment.

**All patients will receive the opportunity to miss one scheduled appointment without a penalty**

**If you are unable to keep your scheduled appointment, we require a 48-hour notice so that we may accommodate the needs of another patient. A \$50.00 fee will be charged to the patient account for any additional late-cancel/missed appointments.**

Thank you for choosing Prince Frederick Dental Center as your dental health provider.

Patient or Legal Guardian Name: \_\_\_\_\_

Patient or Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

