ADVANCED DENTISTRY
WITH A GENTLE TOUCH

PATIENT REGISTRATION 1

If this appointment is for you start here **1**

If this appointment is for your child, start here **1**

Please Complete The Following Confidential Information:

Date **1**
Name
Prefer to be called
Address
City State Zip
Home Phone
Cell Phone
E-mail Address
Birth date Soc. Sec. #
Married Single Divorced Widowed
Date
Name
Prefer to be called
Guardian at appointment
Address
City State Zip
Home Phone
Birth date Soc. Sec #
School

Dental Benefits **2**
Primary Carrier
Employee
Benefit Company
Address
Phone
Group #
Employee ID #
Emp Social Security #
DOB: Date Employed:
Secondary Carrier
Employee
Benefit Company
Address
Phone
Group #
Employee ID#
Emp Social Security #
DOB: Date Employed

Account Information **4**
Person Financially Responsible For Account
Name
Address
Phone SS# DOB:
Bank Branch Account #.
Drivers License #
Your Occupation
Employer
Business Address City
Business Telephone Ext
Your Spouses Name
Spouses Occupation
Spouses Employer
Business Address City
Business Telephone Ext

Getting To Know You **3**
Is another family member or relative a patient at our office? Their Name:
Whom can we Thank for Referring You:
Your Former Address
City State Zip
Person To Contact For Emergency
Their Phone Number
Address
City State Zip
Closest Relative Not Living With You
Phone Number
Address
City State Zip

09/08/2009

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CONSENT FOR TREATMENT 2

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient): _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform recommended treatment mutually agreed upon by me and to employ such assistance as needed to provide proper care.

3. I agree to allow the use of diagnostic adjuncts to communicate with other dental professionals to assist in my care and with insurance companies to allow benefits and for educational purposes and limited publication.

4. I fully understand that I agree to the use of local anesthetics, sedative and other medications as necessary and previously agreed to by me. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a recital of possible complications.

5. We are pleased to reserve time uniquely for you. We will not make another person's appointment at your reserved time. Since a scheduled appointment is a commitment of time between you and our practice, if you find that you cannot keep your scheduled appointment, we ask you to provide a minimum of forty-eight business hours notice to us so we may schedule another patient in need of treatment. If you fail to attend at your reserved time, we may see you on a daily space available basis, rather than by reservation. As an alternative we may also accept a non refundable prepayment for your reservation of time.

Patient Name: _____

Patient Signature: _____ Date: _____

Responsible Party Name: _____ Date: _____

Relationship to Patient: _____

HIPPA Acknowledgement of Receipt of Notice of Privacy Practices

"You may refuse to sign this Acknowledgement"

I, (Name): _____, have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

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DENTAL HISTORY 3

Patient Name

Welcome! *So that we may provide you with the best possible care, please complete both sides of this medical/ dental history form. All information is completely confidential*:

What is the reason for your visit today?_____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning**_____ **Last Full Mouth X-Rays**_____
What was done at your last dental visit?_____

_____

Previous Dentist's Name_____
Address_____State_____Zip_____
Telephone_____

How often do you have dental examinations?_____
How often do you brush your teeth?_____How often do you floss?_____
What other dental aids do you use? (Electric Brush, toothpick,etc.)_____

Do you have any dental problems now? Yes No
If yes, please describe:_____

_____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get Cold sores, Fever blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
(pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

If yes, how many packs a day? _____ for ____ years

Do you feel nervous about having dental treatment? Yes No
If so what is your biggest concern?

_____

Have you ever had an upsetting dental experience? Yes No
If yes, please describe

_____

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No

Please honestly share with us your expectations regarding your treatment, the doctor, the staff and the office:

_____

_____

_____

_____

(Please complete other side)

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MEDICAL HISTORY 4

Patient Name

1. Have you been under the care of a medical doctor during the past two years?.....Yes No

If yes, for what _____
Physician's Name _____ Phone_____
Address_____City_____State_____Zip_____

2. Have you taken any medication during the past two years including appetite suppressants – fen-phen, phentermine or dexfenfluramine or fenfluramine?.....Yes No

3. Are you taking any medication, drugs or pills now?.....Yes No
Including Tagamet(Cimetidine)?…Antacids?… If yes how often?.....
4. Do you take anything to help you rest, relax, or sleep? .....Yes No
If yes, please list name and dosage_____

5. Are you aware of having an allergic (or adverse reaction) to any medication or substance or food?.....Yes No
To Local Anesthetics?..... To Penicillin or Antibiotics… Aspirin…. Codeine, Valium or Sedatives….
6. Have you been a patient in the hospital during the past five years? .....Yes No

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart(Surgery,Disease,Attack).Yes No	Diabetes.....Yes No	Hepatitis B (serum).....Yes No
Chest Pain.....Yes No	Thyroid Problems.....Yes No	Venereal Disease.....Yes No
Congenital Heart Disease.....Yes No	Glaucoma.....Yes No	A.I.D.S.....Yes No
Heart Murmur.....Yes No	Contact Lenses.....Yes No	H.I.V. Positive.....Yes No
High Blood Pressure.....Yes No	Emphysema.....Yes No	Cold Sores/Fever Blisters.....Yes No
Mitral Valve Prolapse.....Yes No	Chronic Cough.....Yes No	Blood Transfusion.....Yes No
Artificial Heart Valve.....Yes No	Tuberculosis.....Yes No	Hemophilia.....Yes No
Heart Pacemaker.....Yes No	Asthma.....Yes No	Sickle Cell Disease.....Yes No
RheumaticFever.....Yes..No	Hay Fever..... .Yes No	Bruise Easily.....Yes No
Arthritis/Rheumatism.....Yes No	Latex Sensitivity.....Yes No	Liver Disease.....Yes No
Cortisone Medicine.....Yes No	Allergies or Hives.....Yes No	Yellow Jaundice.....Yes No
Swollen Ankles.....Yes No	Sinus Trouble.....Yes No	Neurological Disorders.....Yes No
Stroke.....Yes .No	Sore or Enlarged Lymph Nodes Yes.No	Epilepsy or Seizures.....Yes No
Diet(Special/Restricted).....Yes….No	Cancer/Tumors.....Yes..No	Fainting.or.Dizzy.Spells.....Yes…No
ArtificialJoints(hip,knee,etc.)….Yes….No	Radiation Therapy/Biopsies…..Yes No	Nervous/Anxious.....Yes..No
Kidney Trouble.....Yes .No	Chemotherapy.....Yes No	Psychiatric/PsychologicalCare….Yes No
Ulcers.....Yes .No	Hepatitis A (infectious) .....Yes... No	Cosmetic Augmentation .....Yes..No

8.Do you use more than two pillows to sleep?.....Yes No
9.Have you lost or gained more than 10 pounds in the past year?.....Yes No
Height _____ Current Weight _____
10. Do you have or have you had any disease, condition, or problem not listed?.....Yes No
If yes, please list:_____
11. **Women**. Are you: **Pregnant?** Yes_____Months No **Nursing?** Yes No **Taking birth control pills?**.....Yes No
12. **Men**: Are you Taking: Viagara, Cialis or Levitra Yes. No (May change blood pressure when mixed with other meds.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

(Please complete other side)

Patient/Guardian Signature_____Date_____

History Review **Ver.09/08/09**

Findings

M
M
A
S

Dental Management Considerations

Doctor Signature_____ Date_____