katysmiledesign

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PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Today's Date: _____

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

Address: _____ P.O. Box/Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

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

Birth Date: _____ Age: _____ Social Security #: _____

Email: _____ I would like to receive correspondence via ☐ E-mail ☐ Text

MEDICAL HISTORY:

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 medications 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/specialist's care now?	☐ Yes	☐ No	Explain:
Have you been hospitalized or had a major operation?	☐ Yes	☐ No	Explain:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	Explain:
Are you taking any medications, pills or drugs?	☐ Yes	☐ No	Explain:
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates?	☐ Yes	☐ No	Explain:
Are you on a special diet?	☐ Yes	☐ No	Explain:
Do you use tobacco?	☐ Yes	☐ No	Explain:
Do you use controlled substances?	☐ Yes	☐ No	Explain:
Do you drink alcoholic beverages?	☐ Yes	☐ No	How much?:

WOMEN:

Are you pregnant? ☐ Yes ☐ No Trying to get pregnant? ☐ Yes ☐ No Taking Oral Contraceptives? ☐ Yes ☐ No

MEDICAL INFORMATION:

Doctor's Name: _____ Phone: _____ Email: _____

Joint Replacement:

☐ Yes ☐ No Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
If Yes, Date: _____ Doctor's Name: _____ Phone: _____

Were there any complications?

_____

☐ Yes ☐ No Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget 's disease, Multiple Myeloma or metastatic cancer?

Date treatment began _____ Doctor's Name: _____ Phone: _____

Damaged Heart Valve &/or Replacement:

☐ Yes ☐ No Date _____ Doctor's Name: _____ Phone: _____

Patient Name: _____ DOB: _____

Allergies: Are you allergic to any of the following?

Please specify the reaction:

☐ Yes	☐ No	Local anesthetics:	_____
☐ Yes	☐ No	Aspirin:	_____
☐ Yes	☐ No	Penicillin or other antibiotics:	_____
☐ Yes	☐ No	Barbiturates, Sedatives, or sleeping pills:	_____
☐ Yes	☐ No	Sulfa Drugs:	_____
☐ Yes	☐ No	Codeine or other Narcotics:	_____
☐ Yes	☐ No	Metals:	_____
☐ Yes	☐ No	Latex (Rubber):	_____
☐ Yes	☐ No	Hay fever/Seasonal:	_____
☐ Yes	☐ No	Animals:	_____
☐ Yes	☐ No	Food:	_____
☐ Yes	☐ No	Other: _____	_____

Do you have or have you had any of the following? (Please check all that apply and specify if necessary)

- ☐ AIDS/HIV Positive
- ☐ Abnormal Bleeding/Bleeding Disorder
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety Disorder
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Defect
- ☐ Damaged Heart Valves
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Fainting Spells/Dizziness
- ☐ Gastrointestinal Disease
- ☐ GE Reflux/Heartburn
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Malnutrition
- ☐ Mental Health disorders

Specify:

- ☐ Mitral Valve Prolapse
- ☐ Migraines
- ☐ Night Sweats
- ☐ Neurological Disorders
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Persistent Swollen Glands in Neck
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Recurrent Infections

Type of Infection:

- ☐ Rapid Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Heart Disease
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Sleep Disorder
- ☐ Spina Bifida
- ☐ Shingles
- ☐ Stomach/Intestinal Disease
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Swelling in Limbs
- ☐ Systemic Lupus Erythematosus
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes, please specify: _____

Patient Name: _____ DOB: _____

DENTAL INFORMATION

Do your gums bleed when you brush or floss? ☐ Yes ☐ No
Are your teeth sensitive to cold, hot, sweets, or pressure? ☐ Yes ☐ No
Does food or floss catch between your teeth? ☐ Yes ☐ No
Is your mouth dry? ☐ Yes ☐ No
Have you had any periodontal (gum) treatments? ☐ Yes ☐ No
Have you ever had orthodontic (braces) treatment? ☐ Yes ☐ No
Have you had any problems associated with previous dental treatments? ☐ Yes ☐ No
Do you have any earaches or neck pains? ☐ Yes ☐ No
Do you have any clicking, popping or discomfort in the jaw? ☐ Yes ☐ No
Do you clench or grind your teeth? ☐ Yes ☐ No
Do you wear an oral appliance (retainer, nightguard)? ☐ Yes ☐ No
Do you have sores or ulcers in your mouth? ☐ Yes ☐ No
Do you wear dentures or partials? ☐ Yes ☐ No
Do you participate in active recreational activities? ☐ Yes ☐ No
Have you ever had a serious injury to your head or mouth? ☐ Yes ☐ No

Date of last dental exam and cleaning? _____ Date of last dental x-rays? _____

SLEEP QUALITY

Do you snore? ☐ Yes ☐ No

Has your partner / spouse or anyone else told you that you snore and keep them from sleeping comfortably? ☐ Yes ☐ No

Has anyone told you that you stop breathing for a few seconds while you are sleeping? ☐ Yes ☐ No

Do you have a CPAP machine? ☐ Yes ☐ No

Do you have sleep apnea? ☐ Yes ☐ No

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No

If yes, please explain: _____

What is the reason for your dental visit today? _____

SMILE EVALUATION (Please check Yes or No)

Are you missing any teeth? ☐ Yes ☐ No
Are the edges of any teeth worn down, chipped, uneven? ☐ Yes ☐ No
Do any of your teeth appear too small, short, large or long? ☐ Yes ☐ No
Do you have any prior dental work that appears unnatural? ☐ Yes ☐ No
Do you have any crowns or bridges that appear dark at the edge of your gums? ☐ Yes ☐ No
Do you have any gray, black or silver (mercury) fillings in your teeth? ☐ Yes ☐ No
Do you have a “gummy” smile (too much of your gums show when smiling)? ☐ Yes ☐ No
Are your gums red, sore, puffy, bleeding, or receded? ☐ Yes ☐ No
Does the appearance of your smile inhibit you from laughing or smiling? ☐ Yes ☐ No
When being photographed, do you smile with your lips closed instead of flashing a full smile? ☐ Yes ☐ No
Are you self-conscious about your teeth or smile? ☐ Yes ☐ No
Would you like to change anything about the appearance of your teeth or smile? ☐ Yes ☐ No

If you answered YES to ANY of the questions above, there are often several alternatives to improve your teeth and smile. You can have the smile you’ve always wanted!

Additional Dental Concerns: _____

DENTAL BENEFITS INFORMATION

POLICY HOLDER INFORMATION (IF NOT YOURSELF):

First Name: _____ Middle: ___ Last Name: _____ Home Tel: _____

Address: _____ P.O. Box/Apt. #: _____ Work Phone: _____ Ext: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Birth Date: _____ Social Security #: _____ Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION:

Name of Insurance: _____ Group #: _____ ID #: _____

Company Address: _____ Customer Service Phone #: _____

City: _____ State: _____ Zip: _____

Employer: _____ Employer's Phone #: _____

Employer's Address: _____City: _____ State: _____ Zip: _____

1. The undersigned hereby authorize the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me, and to use the appropriate medication and therapy indicated for such treatment in connection with the patient named on this form. I understand that using anesthetic agents embodies a certain risk.
3. I consent to allow the photographs taken to be used for the following: Dental Records, Dental Research, Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books as well as marketing materials including websites, printed materials, and patient education.
4. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are renderd unless other arrangements have been made.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained.
6. I authorize the use of my social security number to file my dental claims.

Signature of patient/parent/or guardian: _____ Date: _____

Please Handle Me With Care

Patient Name: _____

We feel it is necessary to develop a rapport with our patients. Many new patients have had a past unpleasant dental experience. It is crucial to us to know and understand your concerns. We are commited to taking time to get to know you, discuss your concerns, your fears, and your dental expectations.

Please place a check mark in the box next to the statement that concerns you or describes your problem.

- ☐ I gag easily.
- ☐ I feel out of control when I'm lying down for a long time.
- ☐ I feel uncomfortable about what you will say about my teeth and hygiene.
- ☐ Pain relief is a top priority for me.
- ☐ I don't like shots (or I've had a bad reaction to shots).
- ☐ Please tell me what I need to know about my mouth in order to make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise. It is like someone is scratching fingernails on a blackboard.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ Please respect my time, I do not want to be left sitting in the reception area.
- ☐ I want to know the cost up front.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I use/ or am interested in using nitrous oxide (laughing gas) for dental treatment.
- ☐ I am interested in oral sedation, for adults who need deeper state of sedation.