

# DENTAL REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

\_\_\_\_\_

Employer/School Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2 DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and /or my dependents(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ 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 dentist may use my health care information and my 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_

Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_

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

\_\_\_\_\_

Date Relationship to Patient

## 3 PHONE NUMBERS

Home ( \_\_\_\_\_ ) \_\_\_\_\_ Work ( \_\_\_\_\_ ) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Spouse's Work ( \_\_\_\_\_ ) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

## 4 DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental x-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blister on lips for mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often to you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

# 5

## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combination of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Please a mark on "Yes" or "No" to indicate if you have had any of the following:

- |   |  |                       |  |                                    |  |
|---|--|-----------------------|--|------------------------------------|--|
| AIDS/HIV  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with<br>extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on<br>head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |
|   |  | Radiation Treatment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |

So you wear contact lenses?  Yes  No

### Women:

Are you pregnant  Yes  No

Due date \_\_\_\_\_

Are you nursing?  Yes  No

Taking birth control pills?  Yes  No

### MEDICATIONS

List any medication you are currently taking and the correlating diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

### ALLERGIES

- |  |   |
|--|---|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            |
| <input type="checkbox"/> Iodine                        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Latex                         | _____                                     |

# 6

## UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_  \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Cancellation & Insurance Policies For Appointments

---

## 1. ***Cancellation Policy***

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed care.

We ask that if you must change an appointment, please give us 48 hours notice. *Repeated cancellations or missed appointment will result in loss of future appointment privileges.*

**If an appointment is not cancelled at least 48 hours in advance you will be charged a fifty dollar (\$50) fee; this will not be covered by your insurance company.**

## 2. ***Scheduled Appointments***

We understand that delays can happen however, we must try to keep the other patients and doctors on time.

**If a patient is 15 minutes past their scheduled time we may need to reschedule the appointment.**

## 3. ***Insurance Policy***

- I. ALL PAYMENTS FOR SERVICES MUST BE MADE AT THE TIME SERVICES ARE RENDERED (unless prior financial arrangements have been made.)
- II. PATIENTS WITH DENTAL INSURANCE: We will file insurance claims for you. Please keep in mind that filing of insurance claims is a courtesy we are pleased to extend to our patients, but not a requirement. We must highlight that our relationship is with you, the patient(s), and not the insurance company. If we do not receive payment from your insurance company within 45 days, the payment becomes your responsibility. If your family has more than one insurance provider, we will help you in obtaining the maximum benefits possible.
- III. Any balances past due by 90 days or more will be sent to collections at your, the patient's, expense due to payment delinquent status. We keep lines of communication open in resolving this if need be.

---

**Print Name**

---

**Signature**

---

**Date**

# NEW ORCHARD DENTISTRY

PATIENT NAME \_\_\_\_\_

Effective April 14<sup>th</sup>, 2003, the new federal law known as the Health Insurance Portability and Accountability Act (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

I acknowledge that I have received, and/or reviewed the notice of Privacy Practices of this office. I am aware that I may receive a paper copy of this notice. In addition, I acknowledge that this notice of the office's Privacy Practices, is posted in the office where I can review it.

I consent to your disclosures of my information, which you deem necessary in connection with my treatment.

\_\_\_\_\_

\_\_\_\_\_

Patient or Parent's Signature

Date

A good faith effort was made to obtain written acknowledgement of receipt of this office's Privacy Notice.

The patient's signature was not obtained because:

Patient refused to sign

Other reason, \_\_\_\_\_

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

## OPTIONAL

HOW WOULD YOU RATE YOUR SMILE? 1 2 3 4 5 6 7 8 9 10  
(very satisfied)

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_