Patient Registration

The Smile Place
FAMILY DENTISTRY

Today's Date _____

Patient Information

Date of Birth _____ Sex _____

Patient's Name: Last _____ First _____ M.I. _____ SS#_____

Street Address _____ City _____

State _____ Zip _____ Home Phone _____ Cellular Phone_____

Business Phone _____ Patient E-Mail Address _____

Work Information

Patient Employed By _____ Street Address _____

City _____ State _____ Zip _____ Work Phone _____

Who is financially responsible? (if not the patient) _____

Date of Birth _____ SS# _____ Relationship to Patient _____

Home Phone _____ Street Address _____ City _____ State _____

Zip Code _____

Primary Dental Insurance	Primary Medical Insurance
Insurance Co. _____	Insurance Co. _____
Claims Address _____	Claims Address _____
_____	_____
Subscribers Name _____	Subscribers Name _____
Relationship to Patient _____	Relationship to Patient _____
Date of Birth _____ SS# _____ Sex _____	Date of Birth _____ SS# _____ Sex _____
ID# _____ Group# _____	ID# _____ Group# _____
Secondary Dental Insurance	**Secondary Medical Insurance**
Insurance Co. _____	Insurance Co. _____
Claims Address _____	Claims Address _____
_____	_____
Subscribers Name _____	Subscribers Name _____
Relationship to Patient _____	Relationship to Patient _____
Date of Birth _____ SS# _____ Sex _____	Date of Birth _____ SS# _____ Sex _____
ID# _____ Group# _____	ID# _____ Group# _____

HEALTH HISTORY Please Note - all information is held in strict confidence.

Family Physician _____ Phone _____

What brings you to our office today? _____

Emergency Contact _____ Phone _____

Are you presently under a physician's care? YES ☐ NO ☐

If yes, what is the condition being treated? _____

Have any of your immediate family member been treated in our office? YES ☐ NO ☐

Have you taken aspirin or NSAID's within the last 7 days? YES ☐ NO ☐

Have you ever taken or currently taking any other antiresorption or antiangiogenic medications such as PROLIA, XGEVA, or AVASTIN? YES ☐ NO ☐

Are you currently taking blood thinners? YES ☐ NO ☐

Please list all medications you are currently taking:

Medication	**Dosage**	**Why**

List all medications or foods you are allergic to:

Penicillin Sulfa

Codeine Latex

Novocaine Aspirin

Eggs YES ☐ NO ☐

Soy YES ☐ NO ☐

Others _____

Habits - Amounts

Smoke ☐ _____ Packs

Alcohol ☐ _____ Per Day

Drug Use ☐ _____

Have you ever had a problem with drugs or alcohol?

YES ☐ NO ☐ Other _____

Height _____ Weight _____

General	**YES**	**NO**
Tire easily, Weakness	☐	☐
Marked Weight Change	☐	☐
Persistent Fever	☐	☐
Taken Weight Loss Products	☐	☐
Taken Steroids	☐	☐
Skin		
Rashes, Hives	☐	☐
Changes In Skin Color	☐	☐
Eyes		
Eye Problems	☐	☐
Glaucoma	☐	☐
Ears		
Loss of Hearing	☐	☐
Ear Infections	☐	☐
Nose		
Frequent Nose Bleeds	☐	☐
Sinus Problems	☐	☐

Throat	**YES**	**NO**
Frequent Sore Throat	☐	☐
Post Nasal Drip	☐	☐
Cleft Palate	☐	☐
Endocrine		
Diabetes	☐	☐
Thyroid Problems	☐	☐
Other Gland Problems	☐	☐
Nervous System		
Stroke	☐	☐
Frequent Headaches	☐	☐
Convulsions/Epilepsy	☐	☐
Numbness/Tingling	☐	☐
Dizziness/Fainting Nerve	☐	☐
Problems Head Injury	☐	☐
Psychiatric Treatment	☐	☐
Emotional Problems	☐	☐
	☐	☐

Cardiovascular	**YES**	**NO**
Mitral Valve Prolapse	☐	☐
Rheumatic Fever	☐	☐
Any Heart Disease	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure Chest	☐	☐
Pain/Discomfort	☐	☐
Congenial Heart Disease	☐	☐
Artificial Heart Valve	☐	☐
Pacemaker	☐	☐
Scarlet Fever	☐	☐
Heart Surgery	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Respiratory		
Asthma	☐	☐
Emphysema	☐	☐
Bronchitis	☐	☐
Pneumonia	☐	☐
Persistent Cough	☐	☐

Musculoskeletal	YES	NO
Arthritis/Rheumatism	☐	☐
Broken Bones	☐	☐
Artificial Joints/Pins	☐	☐
Parts/Implants	☐	☐
Have You Ever Taken Bisphosphonate Therapy (Actonel, Fosamax, Boniva, Etc.) for Osteoporosis or Osteopenia	☐	☐

Digestive		
Changes In Appetite	☐	☐
Black, Bloody, or Pale Stools	☐	☐
Jaundice	☐	☐
Hepatitis	☐	☐
Stomach Ulcers	☐	☐
Liver Disease	☐	☐

Urinary		
Kidney Disease	☐	☐
Kidney Transplant Venereal Disease	☐	☐
Other	☐	☐

Blood	YES	NO
Bleeding Problems	☐	☐
Blood Disorder	☐	☐
Sickle Cell	☐	☐
Anemia	☐	☐
HIV	☐	☐
Other	☐	☐

Other		
Auto-Immune Disorders	☐	☐
Radiation Treatment	☐	☐
Tumors/Growths	☐	☐
Cancer	☐	☐
Tuberculosis	☐	☐

Family History		
Cancer	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Sickle Cell	☐	☐

Do you have any other significant health concerns currently?

_____

_____

_____

_____

All operations or surgeries

Year

_____ _____

_____ _____

_____ _____

Is there anything else you feel we should know about?

_____

_____

_____

_____

_____

A note of thanks:

Thank you for taking the time to provide us with your health history and insurance information. We appreciate your confidence in our practice to address all of your dental & surgical needs. Our team goes to great lengths to provide the highest level of patient care to support you and your loved ones. We always strive for excellence and utilize the latest and safest state-of-the-art technology to create a positive and seamless overall patient experience.

Consent for Services

As a condition of your treatment by this office, financial agreements must be made in advance. The Practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefor the reasonable value of said services to the doctor or his assignee, at the time of said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless subjected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted here under.

I grant my permission to you or your assignee, to telephone me at my home or at my work to discuss matters related to this form.

I read the above conditions of treatment and payment and agree to their content.
To the best of my knowledge all the preceding answers are true and correct.

_____ Date _____ Relationship to Patient _____

Signature of patient, parent or guardian

_____ Date _____ Relationship to Patient _____

Signature of guarantor of payment/responsible party