

# PATIENT REGISTRATION

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient is:  Policy Holder Preferred Name: \_\_\_\_\_

Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Cellular: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Soc. Sec.: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

### Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Cellular: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec.: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

### Section 2

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

### Section 3

Referred By: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_

### Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec.: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. deduct: \_\_\_\_\_ .00

### Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec.: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. deduct: \_\_\_\_\_ .00

## Medical History

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

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?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you \_\_\_\_\_

Pregnant/Trying to get pregnant?  Nursing?

Taking oral contraceptives.

Are you allergic to any of the following? \_\_\_\_\_

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Sulfa Drugs

Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following? \_\_\_\_\_

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Herpes	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Genital Herpes			

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

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 DATE

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

## Dental History

- Do you have any current dental problems? \_\_\_\_\_
- Date of last completed dental examination \_\_\_\_\_
- Are your teeth sensitive? \_\_\_\_\_
- Do your gums bleed or hurt? \_\_\_\_\_
- Have you noticed any loose teeth or change in your bite? \_\_\_\_\_
- Have you noticed any mouth odors or bad tastes? \_\_\_\_\_
- Does food tend to become caught between your teeth? \_\_\_\_\_
- Do you clench or grind your teeth? \_\_\_\_\_
- Have you ever had Orthodontic treatment? \_\_\_\_\_
- Have you ever seen a Periodontist? \_\_\_\_\_
- Has your bite ever been adjusted? \_\_\_\_\_
- Do you have clicking or popping in your jaw? \_\_\_\_\_
- Do you have difficulty opening or closing your mouth? \_\_\_\_\_
- Have you ever been told you have a TMJ problem? \_\_\_\_\_
- Do you get frequent headaches? \_\_\_\_\_
- Would you like to keep your teeth all your life? \_\_\_\_\_
- Do you feel nervous about having dental treatment?  Yes  No If yes, what is your biggest concern? \_\_\_\_\_
- \_\_\_\_\_
- Have you ever had an upsetting dental experience?  Yes  No If yes, please describe: \_\_\_\_\_
- \_\_\_\_\_
- Are you happy with the appearance of your teeth?  Yes  No If no, what would you like to change? \_\_\_\_\_
- \_\_\_\_\_
- Do you have or are you being treated for sleep apnea?  Yes  No

## Consent for Services

- 1.) I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
- 2.) Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- 3.) I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks.
- 4.) I agree to be responsible for payment of all services on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.
- 5.) I hereby give Dr. Cooley the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensations in connection with the use of said photographs/slides.

\_\_\_\_\_  
Signature of patient, parent or guardian

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_