DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

Name_____

Last First Middle Initial

Gender □Male □Female Date of Birth_____(mm/dd/yyyy)

Check Appropriate Box: □Married □Separated □Divorced □Widowed □Single □Minor □Partnered

Home Address_____

City State Zip Code

Mailing Address_____

Home Phone(_____)_____ Cell Phone(_____)_____

Work Phone(_____)_____ Email Address_____

Person(s) to Contact in Case of Emergency:

Name_____ Relation to Patient_____ Phone_____

Name_____ Relation to Patient_____ Phone_____

How did you hear about our office? Check Appropriate Box Below

□Internet Search □Advertisement □Walk-In □Family/Friend: Name_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account_____

Relation to Patient_____

Mailing Address_____

Home Phone(_____)_____ Cell Phone(_____)_____ Work Phone(_____)_____

For your convenience, we offer the following methods of payment. Payment is expected in full at each appointment. Please check the option you prefer.

□Cash □Personal Check □Credit Card (Visa, MasterCard) □Financing by CareCredit (Must be pre-approved)

INSURANCE INFORMATION (Please provide any/all insurance cards.)

Name of Insured_____

Last First Middle Initial

Relation to Patient_____

Date of Birth of Insured_____(mm/dd/yyyy)

Social Security# or Insurance ID#_____ (required to bill insurance)

Name of Employer_____ Employer Phone(_____)_____

Insurance Company_____

Insurance Phone(_____)_____

Insurance Group#_____ Insurance Policy#_____

Do You Have Any Additional Insurance?** □*Yes* □*No* ***If Yes, Complete the Following:

Name of Insured_____

Last First Middle Initial

Relation to Patient_____

Date of Birth of Insured_____(mm/dd/yyyy)

Social Security# or Insurance ID#_____ (required to bill insurance)

Name of Employer_____ Employer Phone(_____)_____

Insurance Company_____

Insurance Phone(_____)_____

Insurance Group#_____ Insurance Policy#_____

Over Please

PATIENT MEDICAL HISTORY

Physician_____Office Phone_____Date of Last Exam_____

	Yes	No
1. Are you under medical treatment or have you been hospitalized in the last 5 years? If yes, please explain_____	□	□
2. Are you taking any medication(s) including non-prescription? If yes, list_____	□	□
3. Do you use tobacco products, marijuana or recreational drugs? If yes, list_____	□	□
4. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	□	□
5. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? (Affects blood pressure reading.)	□	□
6. Do you have a persistent cough or throat clearing not associated with a known illness lasting more than 3 weeks?	□	□

7. ***Are you allergic to or have had any reactions to the following?*** Please check any that apply.

□Aspirin □Barbiturates (sleeping pills) □Sedatives □Codeine □Iodine □Latex □Local Anesthetics □Penicillin
□Sulfa □Any Metals (nickel, mercury, etc.) □Other_____

8. ***Check appropriate box to indicate if you have had any of the following:***

	Yes	No		Yes	No		Yes	No
High Blood Pressure	□	□	Heart Disease	□	□	Chest Pain	□	□
Heart Attack	□	□	Cardiac Pacemaker	□	□	Easily Winded	□	□
Rheumatic Fever	□	□	Heart Murmur	□	□	Stroke	□	□
Swollen Ankles	□	□	Angina	□	□	Hay Fever	□	□
Fainting/Seizures	□	□	Frequently Tired	□	□	Tuberculosis	□	□
Asthma	□	□	Anemia	□	□	Radiation Therapy	□	□
Low Blood Pressure	□	□	Emphysema	□	□	Glaucoma	□	□
Epilepsy/Convulsions	□	□	Cancer	□	□	Recent Weight Loss	□	□
Leukemia	□	□	Arthritis	□	□	Liver Disease	□	□
Diabetes	□	□	Joint Replacement/Implant	□	□	Heart Trouble	□	□
Kidney Diseases	□	□	Hepatitis (Type_____)/Jaundice	□	□	Respiratory Problems	□	□
AIDS or HIV Infection	□	□	Sexually Transmitted Disease	□	□	Mitral Valve Prolapse	□	□
Thyroid Problem	□	□	Stomach Troubles/Ulcers	□	□	Other_____	□	□

9. ***Women Only:*** ----------

Are you pregnant? □Yes □No Are you nursing? □Yes □No Are you taking oral contraceptives? □Yes □No

PATIENT DENTAL HISTORY

Previous Dentist_____ Date of Last Dental Visit_____

Check appropriate box to indicate if you have had any of the following:

	Yes	No		Yes	No
Bleeding gums while brushing/flossing	□	□	Frequent/Chronic headaches	□	□
Frequent/Chronic bad breath	□	□	Clenching or grinding of teeth	□	□
Sensitivity to hot/cold liquids or foods	□	□	Frequent lip or cheek biting	□	□
Sensitivity to sweet/sour liquids or foods	□	□	Prior difficult tooth extractions	□	□
Pain to any of your teeth	□	□	Prior prolonged bleeding following extractions	□	□
Sores or lumps in or near your mouth	□	□	Orthodontic Treatment	□	□
Any head, neck or jaw injuries	□	□	Do you wear dentures or partials?	□	□
Jaw Clicking	□	□	If yes, date of placement_____		
Jaw Pain (joint, ear, side of face)	□	□	Have you ever received oral hygiene instructions		
Difficulty in opening or closing jaw	□	□	regarding the care of your teeth and gums?	□	□
Difficulty in chewing	□	□	Do you like your smile?	□	□

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Northwest Dental Group, P.C. -La Pine or the treating dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent/guardian if minor)_____ Date_____