REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date______________________________________ SSN/State ID #__________________________________

Patient Name Last:__________________________ First:___________________________ MI:____________

Address:___________________________________ City:__________________State_______Zip: _________

Birthdate: __________________________________

Sex: M F Age:__________ Marital Status: __Married __Single __Minor

E-mail: ____

Mobile: _________________________________ Home Phone: ______________________________________

Work: __________________________________ Emergency Contact: ___________________________________

Best time and method to reach you ______________________________ Do you prefer email reminders? Y / N

2 DENTAL INSURANCE

Subscriber's Name: _____________________________

Birthdate: ________________ ID#:________________

Relationship to Patient:__________________________

Insurance Co: ___________________________________

Group #:___________Employer__________________

Is patient covered by additional insurance? Yes No

Subscriber's Name: _____________________________

Birthdate: _______________ ID#_________________

Relationship to Patient:__________________________

Insurance Co: ___________________________________

Group # _____________Employer________________

ASSIGNMENT AND RELEASE

Your signature is necessary for us to process all insurance claims, ensure payment for services provided, release medical and dental information to insurance companies needed for processing your claims, and to other medical and dental providers, including laboratories, when necessary for your treatment.

I hereby authorize release of all medical information necessary to process my claims and I authorize the same information, when necessary to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I certify that I, and/or my dependent(s), have insurance coverage. I assign all dental, medical, and surgical benefits, including major medical benefits to which I am entitled, to Dr. Kristin Nelson. 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. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

____
Signature of Patient, Parent, Guardian

____
Printed Name

_________________ _______________
Date **Relationship to Patient**

Whom may we thank for referring you to our office? ___________________________________

4 DENTAL HISTORY

Reason for today's visit__________________
____
Former Dentist________________________
City/State ____________________________
Date of last dental visit __________________
Date of last dental x-rays _________________
Place a mark on "yes" or "no" for any of the Following:

Bad Breath	Yes No	Chew on one side of mouth	Yes No	Mouth Breathing	Yes No
Bleeding gums	Yes No	Cigarette, pipe, or cigar smoking	Yes No	Mouth pain, brushing	Yes No
Blisters on lips or mouth	Yes No	Clicking or popping jaw	Yes No	Orthodontic Treatment	Yes No
Burning sensation on gums	Yes No	Dry mouth	Yes No	Pain around ear	Yes No
		Fingernail biting	Yes No	Periodontal Treatment	Yes No
		Food collection between teeth	Yes No	Sensitivity to cold	Yes No
		Foreign objects	Yes No	Sensitivity to hot	Yes No
		Grinding teeth	Yes No	Sensitivity to sweets	Yes No
		Gums swollen or tender	Yes No	Sensitivity when biting	Yes No
		Jaw pain or tiredness	Yes No	Sores or growths in mouth	Yes No
		Lip or cheek biting	Yes No	How often do you floss ___________	
		Loose teeth or broken fillings	Yes No	How often do you brush___________	

5 MEDICAL HISTORY

Physician's Name ____ Date of last visit __________________________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

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

Do you need to pre-medicate prior to dental treatment? Yes No

Women:
Are you pregnant? Yes No Maybe
Are you nursing? Yes No
Taking Birth Control Pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:
____
____
____
Pharmacy Name ________________________________
Phone (_____)_____________________________

NONE

ALLERGIES

Aspirin
Barbiturates (sleeping pills)
Codeine
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa
Other____________

NONE

Getting to know you...

Patient Name ________________________________ Date ____________________

"Our promise to you is the opportunity for a caring, comprehensive, professional dental experience that exceeds your expectations. We will provide you exceptional preventive care to enhance your smile, improve and maintain dental function, and will help you prevent future dental problems."

To help us serve your needs best, we would like to learn more about you. Please take a moment to complete the following questions:

What do you expect from your visit with us today?

____

What is most important to you about your dental health?

____

On a scale of 1 – 10 (10 is highest), how do you rate your dental health? Why?

____

What would you like your teeth to be like in 10 or 20 years?

____

Are you aware that there are medical conditions related to dental disease?

____

What do you know about periodontal disease?

____

Are there foods you enjoy but cannot eat due to discomfort with your teeth?

____

Do you experience any apprehension before or during dental visits? If so, please explain.

____

Please feel free to let us know how we can help make your dental experience with us more pleasant.

____

Smile Evaluation

Please grade your smile using the following scale:

5 = Love it!

4 = Acceptable

3 = Could be better

2 = Do not like it

1 = Hate it!

The whiteness of my teeth _________

The shape of my teeth __________

Appearance of gum tissue __________
(How much gum is showing)

The alignment(straightness) of my teeth _______

The appearance of existing dental work _______

The length of my teeth _______
(Are they even? Do they show enough?)

Comments: