

# PATIENT REGISTRATION

LAST NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
MIDDLE NAME: \_\_\_\_\_ PREFERRED NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ NAME OF PREVIOUS DENTIST: \_\_\_\_\_  
EMPLOYER NAME AND ADDRESS: \_\_\_\_\_ ZIP: \_\_\_\_\_

## PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME: \_\_\_\_\_  
SUBSCRIBER ADDRESS: \_\_\_\_\_  
RELATION TO PATIENT: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
EMPLOYER NAME: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_  
INSURANCE COMPANY NAME: \_\_\_\_\_  
INSURANCE COMPANY ADDRESS: \_\_\_\_\_  
GROUP #: \_\_\_\_\_ FAMILY YRLY DEDUCT: \$ \_\_\_\_\_ INDIV YRLY DEDUCT: \$ \_\_\_\_\_

### *FILING SECONDARY INSURANCE IS THE RESPONSIBILITY OF THE INSURED*

I authorize payment of insurance benefits directly to the dentist of record

\_\_\_\_\_  
(signature)

I authorize release of any necessary medical information to Insurance Company

\_\_\_\_\_  
(signature)

### *GETTING TO KNOW YOU*

Hometown: \_\_\_\_\_ Referred to us by: \_\_\_\_\_

Person to contact for emergency Phone Number Address

Closest Relative Not Living with you Phone Number Address

Is another member of your family, or relative a patient at our office? \_\_\_\_\_

### CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic, aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) \_\_\_\_\_ and further authorize and consent that Doctor choose and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless prior arrangements have been made.

There will be a 1.5% per month Service Charge added to all account balances which remain unpaid 60 days after the treatment is rendered.

*OFFICE POLICY REQUIRES 48 HOUR NOTICE FOR CANCELLATION;  
OR BROKEN APPOINTMENT FEE WILL BE CHARGED TO ACCOUNT.*

### RESPONSIBLE PARTY FOR PATIENT:

Name and Address: \_\_\_\_\_ City State Zip

Signature: \_\_\_\_\_

**YOUR DENTAL AND MEDICAL HISTORY ARE IMPORTANT. MANY THINGS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH. THE INFORMATION YOU PROVIDE IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT PERMISSION.**

### Medical Health

1. **General Health**      Excellent       Good       Fair       Poor

Patients name (PRINT) \_\_\_\_\_ Date \_\_\_\_\_

Name and Address of physician \_\_\_\_\_

Date of Last Complete physical \_\_\_\_\_

Are you taking any prescription/over-the-counter drugs? \_\_\_\_\_

If Yes, Please List Each One: \_\_\_\_\_

2. **Do you have, or have you ever been treated for:**

High/ Low Blood Pressure.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Sinus Trouble.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart Attack.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Asthma.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart Surgery.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Surgical Shunts, Plates or Pins.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart Murmur.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Artificial Joints .....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Stroke.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Kidney Disease.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Artificial Heart Valve.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Thyroid Disease.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart Pacemaker.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Arthritis.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Congestive Heart Disease.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Eating disorders.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Mental Illness.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Hepatitis/ Liver Disease.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Anemia.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Drug or Alcohol Addiction.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Rheumatic Fever.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Glaucoma.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Diabetes.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Cancer.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Epilepsy.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Hemophilia.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Tuberculosis or Lung Disease.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	HIV Positive /AIDS.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Ulcers / Colitis.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Acid Reflux .....	yes <input type="checkbox"/>	no <input type="checkbox"/>

Are you currently taking or have you ever taken bisphosphonates, either orally or by I.V.? ..... yes  no

(examples: Aredia, Zometa, Fosamax, Actonel, Boniva)

Have you ever been treated with radiation therapy or chemotherapy.....yes  no

Are you allergic to any of the following drugs?  Penicillin  Aspirin  Erythromycin  Nitrous Oxide

Dental Anesthetics  Codeine  Tetracycline  Latex

Please list any other drugs that you are allergic to: \_\_\_\_\_

Other physical conditions we should be aware of: \_\_\_\_\_

Are you subject to prolonged bleeding? .....yes  no

Are you taking blood thinners? .....yes  no

Are you subject to fainting spells? .....yes  no

Are you taking birth control pills?.....yes  no

Are you pregnant.....yes  no

### Dental History

**Your current dental health is:** Excellent  Good  Fair  Poor

Dates: last cleaning?\_\_\_\_\_ last cavity detection (bite wings) x-rays? \_\_\_\_\_ last exam?\_\_\_\_\_ last full mouth series x-rays ?\_\_\_\_\_

Do you use:  cigarettes  pipe  chewing tobacco  cigars  gum  alcoholic beverages  coffee  tea  soft drinks

If you have diabetes , what is your normal blood sugar?\_\_\_\_\_how often do you check ? \_\_\_\_\_

How often do you floss your teeth?  1 time  2 times  3 times a day When?  morning  midday  night

How often do you brush your teeth?  1 time  2 times  3 times a day When?  morning  midday  night

Have you had orthodontic treatment (braces)?..... **yes**  no  If yes, when ? \_\_\_\_\_

Have you had previous periodontal care?..... **yes**  no  If yes, when ? \_\_\_\_\_

Electric tooth brush? ..... **yes**  no  What type ? \_\_\_\_\_

Have you experienced residual numbness or unusual sensation around lips or tongue? ....**yes**  no

Have you had any head, neck ,or jaw injuries ?... .....**yes**  no

Do you grind or clench your teeth?..... **yes**  no

Do you have any noticeable wear on your teeth ? ..... **yes**  no

Have you had any complications with extractions? ..... **yes**  no

Are your teeth sensitive to  heat  cold  sweet  sour  chewing? .....**yes**  no  Where ? \_\_\_\_\_

Do you have bleeding gums while brushing or flossing? ..... **yes**  no

Are you aware of any swelling, tenderness or lumps in your mouth? ..... **yes**  no

Do you get cold sores/fever blisters? ..... **yes**  no

Do you have chronic headaches? migraines? ..... **yes**  no

Do you hear  popping  clicking  snapping noises when you chew?..... **yes**  no

Can you chew on both sides of your mouth with-out pain?..... **yes**  no  If no, where is your pain ? \_\_\_

Have you had any unpleasant dental experiences in the past?..... **yes**  no  \_\_\_\_\_

Are you having any dental problems that require immediate attention?.....**yes**  no

Do you have family history of Heart Disease? Diabetes? Periodontal Disease?..... **yes**  no  Explain \_\_\_\_\_

### Cosmetic Dental Makeover: Self-Test

- Are you self-conscious about your smile? .....**yes**  no
- Do you feel your smile makes you look older?.....**yes**  no
- Do you feel your smile looks "older" because your teeth are worn down?..... **yes**  no
- Do spaces or gaps in your teeth make you self-conscious? .....**yes**  no
- Are your teeth stained or too yellow? .....**yes**  no
- Do you notice dark fillings or crowns when you smile? ..... **yes**  no
- Are your teeth crooked, chipped, or crowded?..... **yes**  no
- Do you cover your mouth with your hand when you speak or smile? .....**yes**  no
- Do you avoid smiling when you have your picture taken ? ..... **yes**  no

If you answered "Yes" to any of these questions, you may benefit from Dr. Fleming's Dental Cosmetic Transformation.

**I hereby state that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent , any necessary dental services I may need during diagnosis and treatment.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.