PATIENT REGISTRATION

Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Social Security #: _____

City/State/Zip: _____ Drivers License #: _____

Phone:

Home: _____ Work: _____ Mobile: _____

E-mail: _____

*Please indicate your preference for contact: email or phone (circle one).

Family Status: Married _____ Single _____ Child _____

Gender: Male _____ Female _____

Employer Name: _____

In case of an emergency, who should be notified? Please enter name, phone number and relationship

_____

MEDICAL HISTORY

Have you had any of the following? Please check those that apply:

	Heart Problems		Jaundice		Fainting / Epilepsy
	High Blood pressure		Malignancies		Glaucoma
	Heart Murmur		Radiation Therapy		HIV/ AIDS
	Mitral Valve Prolapse		Chemotherapy		Blood Transfusion
	Artificial Valves		Thyroid Problems		Artificial Joints
	Rheumatic Fever		Respiratory Problems		Allergies
	Diabetes		Asthma		Sinus Problems
	Hepatitis		Tuberculosis		Pregnancy

Are you allergic to any drugs? _____

Are you currently under the care of a physician? _____

If yes, please explain: _____

Are you currently taking any medication: _____

If yes, please list them: _____

Do you have any health problems that need further clarification? _____

If yes, please explain: _____

DENTAL HISTORY

Date of last dental visit: _____Reason for today's visit: _____

Check all that apply:

____Had complications from past dental visits

____Had trouble getting numb

____Had any reactions to local anesthetics

____ Experience dry mouth

____Any teeth sensitive to hot, cold, sweets or avoid brushing any part of your mouth

____Food getting trapped between teeth

____Have you experienced popping or clicking of your jaw joint

____Clenching or grinding your teeth

____ Gums bleed when brushing and flossing

____Treated for gum disease or were told you have lost bone around your teeth

____ Anything about the appearance of your smile that would like to change?

REFERRAL INFORMATION

How did you learn about our practice?

____ Another Patient ____ Another Doctor ____Google ____ Advertisement ____Yelp

Who may we thank for referring you to our practice? _____

POLICY HOLDER INFORMATION

Name: _____ Relation: _____

Date of Birth:_____ SS#: _____

Address: _____ Phone (Home):_____

City/State/Zip:_____ Phone (Mobil): _____

Employer: _____ Dental Insurance: _____

Group #:_____ Subscriber #: _____

Insurance Phone number: _____

CONSENT FOR SERVICES

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at time of visit. Patient is solely responsible for any balance not paid by their insurance company. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for remaining balance, legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize Downtown Dental Design to release any information to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:_____ Date: _____