

**----------------------------------PATIENT REGISTRATION AND MEDICAL HISTORY------------------------------------**

**Date**\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

**Patients Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Single Married Divorced Sex: M F

**Birth date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**HomePhone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_ Zip \_\_\_\_\_\_\_

Driver’s License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Employed By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse/Parent Birth date \_\_\_\_\_\_\_\_\_\_\_

Spouse/Parent Employed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse/Parent:SocialSecurity#\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Company 1) \_\_\_\_\_\_\_\_\_\_ 2) \_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Whom may we thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**-----------------------------------------------MEDICAL HISTORY-------------------------------------------------------------------**

Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last physical\_\_\_\_\_\_\_\_\_\_

Have you ever had any of the following? (Check all that apply)

|  |  |  |
| --- | --- | --- |
| * **Diabetes**
 | * **Respiratory Disease**
 | * **Blood Disease**
 |
| * **Heart Problems**
 | * **Epilepsy**
 | * **Arthritis**
 |
| * **High Blood Pressure**
 | * **Headaches**
 | * **Special Diet**
 |
| * **Low Blood Pressure**
* **Latex Allergy**
 | * **Hepatitis, Jaundice or Live Disease**
* **General Allergies**
 | * **Swollen Neck Glands**
* **Hemophilia**
 |
| * **Circulatory Problems**
 | * **Cancer**
 | * **Sinus Problems**
 |
| * **Nervous Problems**
 | * **Psychiatric Care**
 | * **A.I.D.S.**
 |
| * **Radiation Treatment**
 | * **Chronic Diarrhea**
 | * **Stroke**
 |
| * **Artificial Heart Valves or Joints**
* **Back Problems**
 | * **Allergies to Anesthetics**
 | * **Ulcer**
* **Venereal Disease**
 |
| * **Recent Weight Loss**
 | * **Allergies to Medicines or Drugs**
 | * **Chemical Dependency**
 |

Do you have any drug allergies or have you ever had an adverse reaction to any medication?

If so,what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever responded adversely to medical or dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any mediation at this time? O Yes O No

If so what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician? O Yes O No

For what conditions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If patient is a child, what is his/her weight?\_\_\_\_\_\_\_\_\_Lbs.

(Women) Do you suspect that you are pregnant? O Yes O No Are You Nursing? O Yes O No

Is there anything else we should know about your medical history? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**-----------------------------------------------------------DENTAL HISTORY--------------------------------------------------------------**

Previous Dentist (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last cleaning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental visit and reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any condition in your mouth that is causing you pain or discomfort? Yes No

If yes, what kind:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you do any of the following? (circle all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| * **Bite cheeks or lips**
 | * **Suck finger**
 | * **Breath through mouth**
 | * **Drink tea/coffee**
 |
| * **Bite tongue**
 | * **Bite fingernails**
 | * **Tongue thrust**
 | * **Chew tobacco**
 |
| * **Clench teeth**
 | * **Suck thumb**
 | * **Notice frequent bad breath**
 | * **Smoke**
 |

Are you satisfied with the appearance of your teeth? Yes No

What Can We Do For You Today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND IS ONLY FOR USE IN MY TREATMENT, BILLING AND PROCESSING OF INSURANCE BENEFITS FOR WHICH I AM ENTITLED. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF THE STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

Date: / / Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment and Release**

I, the undersigned, have insurance with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and assign directly to Total Smiles Providers, all benefits, if otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date: / / Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Minor/Child Consent**

I being the parent of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: / / Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Agreement

By signing below I acknowledge the following: (1) I am responsible for any and all payment or co-payments for services rendered. (2) Any claims submitted to insurance which are subsequently declined shall become my responsibility. (3) In the event my owed balance should become delinquent, I acknowledge I may additionally become responsible for additional fees including but not limited to: late fees, collection fees, interest, court costs and attorney fees.

Date: / / Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent**

**I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist’s use and disclosure of my records (or my child’s records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.**

Date: / / Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_