----------**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)

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

_____

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----------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**
- ○ **Bite tongue**
- ○ **Clench teeth**
- ○ **Suck finger**
- ○ **Bite fingernails**
- ○ **Suck thumb**
- ○ **Breath through mouth**
- ○ **Tongue thrust**
- ○ **Notice frequent bad breath**
- ○ **Drink tea/coffee**
- ○ **Chew tobacco**
- ○ **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_____

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