



NEW PATIENT REGISTRATION

SECTION 1: PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
 Address: _____ Apt. #: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone Number: _____ E-mail: _____
 Cell Phone Number: _____ Work Phone Number: _____

SECTION 2: SUBSCRIBER/PARENT/GUARDIAN'S INFORMATION

Name: _____ (self or spouse): _____
 Social Security #: _____ Date of Birth: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Employer: _____

SECTION 3: SUBSCRIBER/PARENT/GUARDIAN'S INSURANCE INFORMATION

Name of Insurance Company: _____
 Group ID #: _____ Subscriber's ID: _____
 Claims and Benefits Phone #: _____ Payor ID #: _____
 Claims Address: _____ City: _____ State: _____ Zip Code: _____

SECTION 4: INSURANCE BREAKDOWN *(for office use only)*

Deductible: Ind. \$ _____ Family \$ _____ On Preventive _____ Met for Year: _____
 Preventive _____ % Basic _____ % Major _____ % Based On: _____
 Yearly Maximum: \$ _____ Amount Used to Date: \$ _____
 Waiting Period: Basic Work _____ Major Work _____
 Sealants Covered: _____ % Up to Age _____ Night guards (9940) Covered: _____ %
 Fluoride Covered: _____ % Up to Age _____
 Periodontal Coverage: Maintenance (4910) Yes/No Frequency: _____ SRP: _____
 Full Mouth Debridement (4355) Covered: _____ Arestin (4381): _____ Eligible: _____
 Replacement Clause: Crowns and Bridges every _____ years Missing Tooth Clause: _____
 Partial and Dentures every _____ years
 Frequencies: Cleanings: _____ Exams: _____ BW: _____ FMX: _____
 Last FMX: _____ Composite downgraded to Amalgam: (Y/N) _____ Hx: _____
 Are services for BW, PA, and FMX/PAN combined/downgraded? (Y/N) _____
Insurance Company Representative:
 Name: _____ Date: _____ Time: _____

SECTION 5: DENTAL HISTORY

Name: _____ male/female Age: _____

Former Dentist: _____

Reason for Today's visit: _____

Date of last exam: _____ Date of last dental x-rays: _____

How often does the patient brush? _____ How often does patient floss? _____

Please check any of the following conditions that apply to the patient:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when brushing |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in the mouth |

SECTION 6: MEDICAL HISTORY

Physician/Pediatrician _____ Date of Last Visit _____

Please list all medication you are currently taking: _____

Allergies: _____

(Women) Are you pregnant? Yes / No Nursing? Yes / No Taking birth control? Yes / No

Please check if the patient has a history of any of the following?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | Describe _____ | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |

SECTION 7: AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (Or parent/guardian if a minor)

Date