**New Patient Registration**

*The following information is required by the dentist to assist in proper diagnosis and treatment.*

*All information is confidential.*

Last name: Click or tap here to enter text. First Name: Click or tap here to enter text.

Address: Click or tap here to enter text.

City:Click or tap here to enter text. Postal Code: Click or tap here to enter text.

Home Phone: Click or tap here to enter text. Cell Phone:Click or tap here to enter text.

Work Phone:Click or tap here to enter text.

Gender: Click or tap here to enter text. Date of Birth: Click or tap to enter a date.

Email:Click or tap here to enter text.

Family Physician: Click or tap here to enter text. Phone Number: Click or tap here to enter text.

Medical Specialist (If under present care): Click or tap here to enter text.

Pharmacy: Click or tap here to enter text. Phone Number: Click or tap here to enter text.

Health Card Number: Click or tap here to enter text.

Emergency contact:

Name: Click or tap here to enter text. Phone Number: Click or tap here to enter text.

**Insurance Information**

Insurance Company: Click or tap here to enter text.

ID Number: Click or tap here to enter text. Policy Number: Click or tap here to enter text.

Employer: Click or tap here to enter text.

Reason for Visit (check one): Exam Emergency  Other: Click or tap here to enter text.

How did you find out about us? Click or tap here to enter text.

Whom may we thank for referring you? Click or tap here to enter text.

**Dental History:**

Date of last dental visit: 0-6months 6-12months +12months

Last Cleaning: Click or tap here to enter text.Last X-rays Taken: Click or tap here to enter text.

Other treatment received: Click or tap here to enter text.

**Have you had any of the following dental treatments/services? (Check all that apply)**

Orthodontic Treatment (braces) Periodontal (Gum) Treatment Implants

Bite adjustment Full/Partial Dentures Oral Surgery

Root Canal Treatment Crowns or Bridges

Other: Click or tap here to enter text.

Are any of your teeth sensitive to: Cold Sweets Heat Other Click or tap here to enter text.

Do your gums bleed while brushing or flossing? Yes/No

Do you suffer from pain and/or swelling of your gums? Yes/No

Do you feel any pain in any of your teeth? Yes/No

Do you have any sores or lumps in or near your mouth? Yes/No

Have you had any head or neck injuries? Yes/No

Have you ever had an injury, surgery, or x-ray therapy to your face/jaws? Yes/No

Have you experienced any of the following problems in your jaw?

-Clicking, Cracking, or popping when opening or closing your jaw Yes/No

-Difficulty in opening or closing Yes/No

-Pain (Joint/ear(s)/side of face) Yes/No

-Difficulty chewing Yes/No

Have you ever had any prolonged bleeding following extractions? Yes/No

Are you aware of any loose teeth? If yes, where:Click or tap here to enter text. Yes/No

**Habits, Do you:**

- Grind or clench your teeth (day or night) Yes/No

- Chew on only one side of your mouth- Why? Yes/No Click or tap here to enter text.

- Mouth breathe while awake or asleep? Yes/No

-Bite your lips or cheeks regularly? Yes/No

-Hold any foreign objects with your teeth (pencils, nails etc.)? Yes/No

-Gag easily Yes/No

Does any part of your mouth hurt when clenched? Yes/No

Wear full or partial dentures?Yes/No

If yes, when were they made? Click or tap here to enter text.

Is there anything about the appearance of your teeth that you would like to change, and if so, what would you like to see changed? Click or tap here to enter text.

How would you rate your current dental health? Excellent Good Fair Poor

Sugar Intake: High Medium Low

Brushing: Vigorous Light How Often? Click or tap here to enter text.

Cleaning aids presently used: floss stimudents toothpick OtherClick or tap here to enter text.

Do you have any emotional concerns regarding your dental visit?

Fear Pain Time Money Embarrassment Other

**IN ORDER TO AVOID COMPLICATIONS AS A RESULT OF A CHANGE IN YOUR MEDICAL CONDITION, IT IS IMPORTANT THAT YOU NOTIFY OUR OFFICE OF THESE, OR ANY, CHANGES.**

**Authorization and Release:**

I certify that I have read, understood, informed myself about, and answered the medical-dental questionnaire to the best of my knowledge, and I have not knowingly omitted any information. I hereby promise to inform you or any change in the state of my heath. I understand that providing incorrect health information can be dangerous to mu health. I authorize the dentist to release any information including the diagnosis and the third-party payers and/ or health practitioners.

Click or tap here to enter text. Click or tap to enter a date.

Signature of Patient Date

**ASSIGNMENT OF BENEFITS AGREEMENT**

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

**Please Initial**

Click or tap here to enter text. Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save your time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

Click or tap here to enter text. We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.

Click or tap here to enter text.We require you to pay the estimated co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. The co-payment is only an estimate of charges and may be found to be insufficient after review by your insurance company.

Click or tap here to enter text.Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time. You have the option of being directly reimbursed from your insurance company. If you choose to do so, all fees will be due at the time of service.

Click or tap here to enter text.Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

Click or tap here to enter text.Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

**I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.**

Print Name of Patient or Responsible Party:Click or tap here to enter text.

Signature of Patient or Responsible Party: Click or tap here to enter text.

Date: Click or tap to enter a date.

**Medical History**

Are you currently under the care of a physician? YES  NO

If Yes Explain: Click or tap here to enter text.

Have you ever been hospitalized or had a major operation?  YES  NO

If Yes Explain: Click or tap here to enter text.

Have you ever had a serious head or neck injury?  YES  NO

If Yes Explain: Click or tap here to enter text.

Are you taking any medications, pills or drugs?  YES  NO

If Yes Explain: Click or tap here to enter text.

Are you on a special diet?  YES  NO

Do you use tobacco?  YES  NO

Do you use controlled substances?  YES  NO

Do you use recreational drugs?  YES  NO If Yes when last used: ­­­­­­­­­­­­­­­­­­Click or tap here to enter text.

Do you consider yourself a special needs person?  YES  NO

Women: Are you…

Pregnant or trying to get pregnant?  Nursing?  Taking oral contraceptives?

Do you have any allergies?  YES  NO

Please list if any: Click or tap here to enter text.

Sign: Click or tap here to enter text. Date Click or tap to enter a date.

**Do you have or have you ever had any of the following?**

AIDS/ HIV Positive Y / N Frequent Cough Y / N Psychiatric Care Y / N

Alzheimer’s Disease Y / N Frequent Diarrhea Y / N Radiation Treatments Y / N

Anaphylaxis Y / N Frequent Headaches Y / N Recent Weight Loss  Y / N

Anemia Y / N Genital Herpes Y / N Renal Dialysis  Y / N

Angina Y / N Glaucoma Y / N Rheumatic Fever Y / N

Arthritis/Gout Y / N Hay Fever Y / N Rheumatism  Y / N

Artificial Heart Valve Y / N Heart Attack/Failure Y / N Scarlet Fever Y / N

Asthma Y / N Heart Murmur Y / N Shingles  Y / N

Blood Disease Y / N Pacemaker Y / N Sickle Cell Disease  Y / N

Blood Transfusion Y / N Heart Disease Y / N Sinus Trouble  Y / N

Breathing Problems Y / N Malignant Hypothermia Y / N Spina Bifida  Y / N

Bruise Easily Y / N Hemophilia Y / N Stomach trouble Y / N

Cancer Y / N Hepatitis A / B / C Y / N Stroke Y / N

Chemotherapy Y / N Herpes Y / N Swelling of Limbs  Y / N

Chest Pains Y / N High Blood Pressure Y / N Thyroid Disease  Y / N

Cold Sores Y / N High Cholesterol Y / N Tonsillitis  Y / N

Congenital Heart Disorder Y / N Hives or Rash Y / N Tuberculosis  Y / N

Convulsions Y / N Hypoglycemia Y / N Tumors or Growths  Y / N

Yellow Jaundice Y / N Irregular heartbeat Y / N Ulcers  Y / N

Cortisone Medicine Y / N Kidney Problems Y / N Venereal Disease Y / N

Diabetes Y / N Leukemia Y / N Fainting  Y / N

Drug Addiction Y / N Liver Disease Y / N Parathyroid Disease  Y / N

Easily Winded Y / N Low Blood Pressure Y / N Excessive thirst Y / N

Emphysema Y / N Lung Disease Y / N Pain in Jaw Y / N

Epilepsy or Seizures Y / N Mitral Valve Prolapse Y / N

Excessive Bleeding Y / N Osteoporosis Y / N