Family Dentistry
Registration and Health History
Patient Information

Patients name: *Last* _____ ***First*** _____ ***MI*** _____

Address: *Street* _____ *City*_____ *State* _____ *Zip*_____

Cell phone #: _____ **Work** #: _____ **DOB**: _____ **Marital Status**_____

Social Security #: _____ **Occupation**: _____ **Sex**: M F

Email Address for confirmation purposes only: _____

Responsible Party (*parent or guardian if patient is a minor)*

Parent's Name: *Last*_____ *First* _____

Cell phone #: _____ Work #: _____

Emergency Contact

Name: *Last* _____ *First* _____ *Phone #* _____ *Relationship* _____

Dental History

Reason for today's visit: _____ Former Dentist: _____

When was your last exam? _____ Were x-rays taken? Y N

How often do you brush? _____ How often do you floss? _____

Are you happy with the appearance of your teeth? Y N

Are you interested in cosmetic dentistry? Y N

Are you nervous about Dental Treatment? Y N

Please circle the following conditions that apply to you:

Bad Breath	Grinding Teeth	Sensitivity to hot/cold	Bleeding Gums
Loose Teeth	Sensitivity to sweet	Broken Fillings	Food collections in teeth
Clicking/ Popping Jaw	Sensitivity when biting	Sores or growth in mouth	Periodontal Treatment

Medical History

Physician: _____ **Date of last visit**: _____

Please list any Prescribed or over the counter Medicines that you are taking: _____

_____

Please list any Drug or Chemical Allergies: _____

Please Circle the following conditions that apply to you:

ADD/ADHD	Circulatory Problems	Hemophilia	Scarlet Fever
AIDS	Cortisone Treatments	Hepatitis	Shortness of breath
Alzheimer	Cough, Persistent	High Blood Pressure	Sickle Cell Anemia
Anemia	Cough up Blood	HIV	Skin Rash
Arthritis	Diabetes	Jaw Pain	Swelling (ankle/feet)
Artificial Heart Valves	Down Syndrome	Kidney Disease	Thyroid problems
Artificial Joints	Epilepsy	Liver Disease	Tobacco Habit
Asthma	Fainting	Mitral Valve Prolapse	Stroke
Autism	Fever Blisters	Nervous Disorder	Tonsillitis
Back Problems	Glaucoma	Pacemaker	Tuberculosis
Blood Disease	Hay Fever	Psychiatric Care	Ulcer
Cancer	Headaches	Radiation Treatment	Venereal Disease
Chemical Dependency	Heart Murmur	Respiratory Disease	Others Not Listed:
Chemotherapy	Heart Problems	Rheumatic Fever	_____

Females: Are you pregnant**? Y N** Are you nursing**? Y N** Taking Birth Control Pills**? Y N**

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 questions not answered or incorrectly answered can be hazardous to my health.

Signature of Responsible Party:_____**Date**:_____

Whom may we thank for referring you to our office? _____

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Notice of Privacy Practice Acknowledgement

I acknowledge that I have been informed of your notice of Privacy Practice, which contains complete description of the use and disclosure of my health information. I understand that the notice will be provided to me at my request.

Patients Name (please print): _____

Patients Signature: _____ Date: _____

If Patient is a minor and/ or personal representative of the patient signs on behalf of the patient, please complete the following:

Patient's Name (please print): _____

Relationship to patient: _____

Signature: _____

Date: _____

************************************For Office Use ONLY ***********************************

An effort was made to obtain a signature that the individual received a copy of the Notice of Privacy Practice, but was unable to do so as documented below.

Date: _____ Initials: _____

Patients Name: _____

Reason:

_____

_____

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APPOINTMENT AGREEMENT

Welcome to our wonderful family of patients! Thank you for selecting us as your dental care team. We are confident your relationship with us will be a pleasant and rewarding one! We provide our patients with the optimal clinical care in a warm, caring, comfortable environment.

In order for us to respect the time of all of our patients, we ask that you help us in regards to the appointments that have been specifically reserved for you!

PLEASE BE ON TIME FOR YOUR APPOINTMENTS.

If you're late: Here at Dr. Do's dental office, when we reserve time for you, we require all of that time to provide you with the best quality care possible. When you are late, it decreases our ability to accomplish this. If you arrive more than 10 minutes late for your appointment time, you may be rescheduled in order to meet the needs of those who are on time and a $75 fee may be assessed per each scheduled appointment.

WE REQUIRE 48 HOURS (1 business day) NOTICE WHEN CHANGING OR RESCHEDULING YOUR APPOINTMENT.

This allows us to offer your time slot to another patient who is in need of dental care. If a 48 hour notice is not given or you fail to show up for your appointment at your scheduled time, we will assess a $75 cancelation fee.

**********************Attention Insurance Patients***********************

We will file your insurance claims as a courtesy for you and will accept "assignment of benefits" on your behalf. Regardless of what we may calculate your insurance company to pay, it is only an estimate. The financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company. Therefore, you will be financially responsible for any balances not paid by your insurance company. Any balances past 30 days is assessed a $15 late fee. Any balances past 60 days will be sent to Transworld Collection Agency.

We thank you for your understanding and partnership in this matter.

My signature indicates that I have read this and agree to its consent.

_____ _____

Name (first, last) Date

_____

Team Member

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Take Our Smile Assessment!

Yes	No	
❑	❑	Are you happy with the appearance of your teeth?
❑	❑	Do you have unsightly crowns or fillings?
❑	❑	Are your gums or teeth sensitive?
❑	❑	Do you like the color of your teeth?
❑	❑	Are you missing teeth?
❑	❑	Are you interested in improving the appearance of your teeth?
❑	❑	Are you familiar with the benefits of dental implants?
❑	❑	Are you anxious or fearful of treatment?
❑	❑	Are you happy with the alignment of your teeth?
❑	❑	Is fear holding you back from a perfect smile?
❑	❑	Is lack of time holding you back from a perfect smile?
❑	❑	Is cost holding you back from a perfect smile?
❑	❑	Is there something else not listed holding you back from a perfect smile?

Please feel free to explain any answers.