Patient Registration

Account _____ Date _____

Patient Information

Name _____

I preferred to be called _____
( ) male ( ) female ( ) non-binary
Preferred pronouns _____

Martial status S M D W

DOB _____-_____-_____ SSN _____-_____-_____

Home address
_____

City _____ State _____ Zip _____

Preferred method of contact
- Cell/home phone _____
- Work phone _____
- Email _____

Employer_____
Occupation _____

How did you hear about our office? If referred, whom may we thank?
_____
Please list other family members seen by us
_____
_____

Billing Information / Responsible Party

- Same as patient

Name _____
Relationship _____

DOB _____-_____-_____ SSN _____-_____-_____

Home address
_____

City _____ State _____ Zip _____

Preferred method of contact
- Cell/home phone _____
- Work phone _____
- Email _____

Employer_____
Occupation _____

Smiles@Southcenter

Dental Insurance Yes No
Medical Insurance Yes No
If yes, please provide ID cards

Emergency Contact
Name _____
Relationship _____
Phone _____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Smiles@Southcenter Dentistry's doctors and treatment staff to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize S@S to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that S@S choose and employ such assistance as deemed necessary. I understand that the use of local anesthetic agents embodies certain risks and consent to their use as deemed appropriate by S@S. To the best of my knowledge, the questions on these registration forms have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance. I further consent to agree to pay a 1.5% finance charge that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize S@S and its staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal. I understand that appointments changed without 24 hours notice may be assessed a broken appointment charge.

Signature _____

Date _____

Name _____

Medical History

Your current physical health is: ( ) good ( ) fair ( ) poor
MD name _____
MD phone _____
Last physical exam _____
Are you currently under a physician's care? Y N
Explain _____
_____
_____

Medications

List all currents medication and reason for use (use reverse side if necessary)
Medication Use
_____
_____
_____

Check all that apply:

Allergies

- Acrylic
- Anaphylaxis
- Aspirin
- Codeine
- Erythromycin
- Ibuprofen
- Iodine
- Latex
- Local Anesthetics
- Metal (jewelry)
- Penicillin

Other _____

Cardiovascular

- Artificial heart valve
- Endocarditis or bacteremia
- Heart murmur or congenital defect
- Heart attack
- Heart disease/surgery
- High/low blood pressure
- Irregular heartbeat
- Mitral valve prolapse
- Pacemaker

Endocrine

- Diabetes
- Thyroid hypo/hyper

Ears, Eyes, Nose and Throat

- Difficulty swallowing
- Ear pain
- Hay fever
- Hearing issues
- Sinus issues
- Tonsillectomy
- Vision issues

Gastrointestinal

- Acid reflux
- GERD

Genitourinary

- Frequent urination
- Kidney disease

General / Other

- Autism
- Cancer
- Chemotherapy
- Headaches
- HIV/AIDS
- Liver issues
- Radiation treatment
- Rheumatic fever
- Traumatic injury

Hematological

- Bleeding disorder
- Blood thinners
- Hepatitis

Musculoskeletal

- Back pain
- Bisphosphonate use (Fosamax, Boniva)
- Fibromyalgia
- Joint Pain
- Joint replacement hip, knee, shoulder
- Muscle weakness

Neurological

- Alzheimer's or dementia
- Fainting
- Memory loss
- Multiple sclerosis
- Seizures
- Stroke
- Trigeminal neuralgia
- Tremor

Mental Health

- ADD/ADHD
- Anxiety
- Alcohol dependency
- Chemical dependency
- Depression
- Eating disorder

Respiratory

- Asthma
- Breathing difficulty
- Emphysema

Sleep

- Daytime sleepiness
- Morning headaches
- Sleep apnea
- Do you use a CPAP?
- Do you snore?

Social History

- Smoke, how often?
- Smokeless tobacco, how often?
- Alcohol, how often?
- Recreational drugs, how often?

Other Illness Not Listed:

_____

For Women:

Are you pregnant or nursing ? Y N

Signature _____
Date _____

Smiles@Southcenter

Dental History

Name _____

Name of last dentist _____ City/State _____

Office phone _____ Date of last exam _____

Date of last cleaning _____ How often were your teeth cleaned? _____

Reason for today's appointment _____ _

What does your typical oral hygiene routine include?

- Manual toothbrush, frequency _____
- Electric toothbrush, frequency _____
- Floss, frequency _____
- Floss aids, frequency _____
- Toothpicks, frequency _____
- Interproximal aids, frequency _____
- Rinses, frequency _____
- Waterpik, frequency _____

1. Do you feel pain in any of your teeth? Y N _____
2. Are your teeth sensitive to hot or cold? Y N _____
3. Are your teeth sensitive to sweet or sour things? Y N _____
4. Do your gums bleed when brushing or flossing? Y N _____
5. Do you have any sores or bumps in or near your mouth? Y N _____
6. Does your mouth ever feel dry? Y N _____
7. Have you had any injuries to your head, neck, or jaw? Y N _____
8. Have you ever had any of the following problems in your jaw? Y N _____
   - Clicking or popping Y N
   - Pain with opening or closing Y N
   - Difficulty chewing Y N
   - Dislocation Y N
9. Have you ever been treated for periodontal disease (deep cleaning)? Y N _____
10. Do you clench or grind your teeth? Y N _____
11. Do you have frequent headaches? Y N _____
12. Do you bite your lips or cheeks frequently? Y N _____
13. Have you ever had orthodontic treatment? Y N _____
    - If yes, when and do you wear retainers? Y N
14. Do you wear dentures or partials? Y N _____
    - If yes, date made _____
15. Are you nervous or anxious about having dental care? Y N _____
16. Have you had any difficulty getting completely numb? Y N _____
17. Have you experienced unfavorable dental care? Y N _____
18. Is there anything you would like to change about your teeth or smile? Y N _____
    _____

Signature _____ Date _____