PATIENT REGISTRATION

Full Name: ____ Gender: M F
Last *First* *MI* *Preferred Name* *Title* Family Status: M S C

Birth Date: ________________ Email Address: ____________________________________

Phone: ______________________ ______________________ ______________________
Home *Work* *Cell*

Preferred Contact Method: Home Work Cell Email Text

Address: ____
City *State* *Zip Code*

Employer's Name: ____________________________ Occupation: ____________________________

How did you hear about our office? ____

Spouse Name (or parent if minor): ____________________ Spouse Phone Number: ____________________

Emergency Contact Name: ____________________ Emergency Contact Phone Number: ____________________

Person Financially Responsible for this Account

Name: ____________________ Relationship to Patient: __________ Phone Number: ____________________

Address: ____
City *State* *Zip Code*

Email Address: ______________________________

Primary Dental Insurance Information

Name of Insured: ______________________________ Relationship to Pt: ____________________
Last *First* *MI*

Insured's Birth Date: ______________ Phone #: ____________________ Email Address: ____________________

ID #: ____________________ Group #: ____________________

Insured's Address (if different from patient's): ____
City *State* *Zip Code*

Insured's Employer Name: ______________ Employer's Address: ______________________________

Insurance Plan Name: ____________________ Insurance Phone #: ____________________

Insured's Social Security #: ____________________ Patient's Social Security #: ____________________

I grant permission for you to submit my dental insurance and accept the payment to your office.

I grant permission to you or your office staff to contact me about my appointments, financial arrangements, or my treatment.

____
Signature (Parent if minor) Date

Dental History

Name:____**Date:**_________________________________

Date of Last Dental Visit:_____________________________ Date of Last Cleaning:___________________________

What was done at your last dental visit?____

Previous Dentist's Name:____

Address:____ Phone: ___________________________

How often do you have dental examinations?____

How often do you brush your teeth?____

How often do you floss your teeth? ____

What type of toothbrush do you use? Soft Medium Hard Electric

What type of toothpaste do you use? Tartar Control Sensitivity Whitening Fluoride

Do you use any other dental aids or rinses? ____

Do you have any dental problems or concerns now? Yes No

If yes, please describe: ____

Are you satisfied with the appearance of your teeth? Yes No

If no, what would you like to change? ____

Are any of your teeth sensitive to:

Hot or cold?	Y	N
Sweets?	Y	N
Biting or Chewing?	Y	N

Have you been told that you have gum disease?	**Y**	**N**
Do your gums bleed or hurt?	Y	N
Have you noticed bad breath or mouth odor?	Y	N
Have you noticed loose teeth / change in your bite?	Y	N
Have your parents had gum disease or tooth loss?	Y	N
Does food "pack" in between teeth?	Y	N

If yes, where?_________________________________

Do you:

Clench or grind your teeth?	Y	N
Bite your cheeks or lips regularly?	Y	N
Hold foreign objects with your teeth (nails, pins)?	Y	N
Breathe through your mouth?	Y	N
Have tired / sore jaw muscles especially in the am?	Y	N
Smoke / Chew tobacco?	Y	N

Have you ever had:

Orthodontic treatment (braces)?	Y	N
Retainers?	Y	N
Oral Surgery?	Y	N
Periodontal Treatment?	Y	N
Bite adjustment?	Y	N
Bite plate or mouth guard?	Y	N
Dentures / Partials?	Y	N
Serious injury to mouth or head?	Y	N

If yes, please describe:___________________________________

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Have you experienced:

Clicking or popping of the jaw?	Y	N
Pain in your jaw joint?	Y	N
Difficulty opening or closing?	Y	N
Difficulty chewing?	Y	N
Headaches, neck aches, or shoulder aches?	Y	N

Do you feel anxious about receiving dental treatment? Y N

If yes, what is your biggest concern?______________________

Have you ever had an upsetting dental experience? Y N

If yes, please describe__________________________________

Is there anything else about your dental treatment that you would like us to know?

Name:____ Date:______________________________

Please fill out the health history to the best of your knowledge. Although dentists primarily treat the area in and around your mouth, health problems that you may have or medication that you may be taking could be significant in the care that you will be receiving in our office. Your answers are to provide proper care for you and will be kept confidential.

Have you had any serious illness, operation, or hospitalization in last 5 years? Y N
Explain:____

Are you under the care of a physician for any condition? Y N Explain:________________________________

Physician Information:____

Please list or attach a copy of all medications, vitamins, or herbal supplements:

____

Do you have allergies, sensitivity, or reactions to any of the following:

___Penicillin ___Local Anesthetic ___IV Sedation

___Sulfa Drugs ___Latex ___Other:______________________

Have you ever taken antibiotics prior to dental treatment? Y N Explain:_______________________________________

Have you had or been treated for: _____ Multiple Myeloma _____ Metastatic Cancer _____ Pagets Disease ____ Osteoporosis

Have you had Bisphosphonate Therapy? ____ Actonel ____ Boniva ____ Fosamax ____ Skelif ____ Didronel
____ Aredia ____ Zometa ____Other:________________________ How Long:__________

Do you have or have you been treated for any of the following conditions:

Anemia

Anxiety

Arthritis

Artificial heart valves

Asthma

Back problems

Birth Control or Hormones

Blood Disease or Bleeding Disorder

Bulimia

Cancer or Tumor

Chemotherapy

Chronic Cough

Circulatory Problems

Contact Lenses

Corticosteroid Treatment

Depression

Diabetes

Dizziness/Vertigo

Drug or Alcohol Use

Joint replacement (hip, knee)

Epilepsy/seizures

Fainting

Glaucoma or Cataracts

Hay Fever/Sinus Problems

Headaches

Heart attack

Heart Problems or Surgeries

Hearing Impairment or Aid

Hemophilia

Hepatitis, jaundice, or liver disease

High Blood Pressure

HIV/AIDS

Hypoglycemia

Infective Endocarditis

Immune System Problems

Kidney Disease

Limited Mobility

Lupus

Mononucleosis

Pacemaker

Pregnancy / Nursing

Psychiatric or Mental Disorder

Radiation Treatment

Respiratory Disease/Emphysema/COPD

Sexually Transmitted Disease

Stomach Ulcers/Hyperacidity/Reflux

Stroke

Thyroid Disease

Tobacco Use

Transplant

Tuberculosis

Vision Impairment

Other:__________

All of the above information is correct to the best of my knowledge. I agree to update Dr. Hall and team to any changes in my health prior to dental treatment.

____

Signature Date

Important Information for our Patients

Dental Insurance:

We are glad to assist you with your dental insurance plan. To help us assist you in obtaining your maximum benefit, please ***bring your insurance card to your first visit.*** Once your plan coverage has been verified, we will accept assignment of payment from your insurance company. Most plans only cover a portion of the dental fee, which means you will be responsible for your deductible and the portion your plan does not cover. The estimated amount of your portion is expected at the time you are in our office for dental care, unless prior arrangements have been made. If the insurance company does not pay the entire estimated amount, you will be billed for the remainder. If, after 60 days, your insurance company has not provided payment for services rendered, the remaining balance will become your responsibility.
Secondary Insurance: We do not accept assignment of benefits on a secondary insurance. If you have a secondary insurance, we will help you file the necessary forms and the reimbursement will be paid to you. You are asked to pay the amount that your primary insurance does not cover.

Payment Options:

For your convenience, we accept VISA, MasterCard, American Express, Discover, cash, and personal checks. Our office offers extended payment plans, please ask about these options. Please remember that if you receive a statement from our office that it is due within 30 days. A late fee will be applied to payments received after the due date.

Appointments:

Our appointments are scheduled to respect your time. We reserve a specific time for your care and we make every effort to see you as scheduled. We appreciate your promptness and consideration in not changing your scheduled time. However, if you do need to change an appointment, a 48-hour notice is expected. A cancellation fee of $45 will be applied to your account after the second cancellation with less than 48 hours notice.

I have read and agree with the above information.

____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, ____, have received a copy of this office's

Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual Refused to Sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)

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