

Patient Registration



Please complete the following confidential information

Date _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Prefers to be called: _____ Date of Birth: _____

Address: _____ City _____ Zip _____

Home Ph: _____ Cell Ph: _____ Alt Ph: _____

Email: _____ What is the best way to contact you? _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Domestic Partner _____ Student _____ FT _____ PT _____

RESPONSIBLE PARTY

(if different from above)

Last Name: _____ First Name: _____ MI: _____

Address: _____ City _____ Zip _____

Best phone number to be reached at: _____ Email: _____

Relationship to patient: _____

INSURANCE INFORMATION

Insurance Company: _____ Group#: _____

Employer: _____ Ph: _____

Insured's Name: _____ Date of Birth: _____

Insured's ID/SS: _____ Relationship to patient: _____

Secondary Ins. Co.: _____ Group# _____

Employer: _____ Ph: _____

Insured's Name: _____ Date of Birth: _____

Insured's ID/SS: _____ Relationship to patient: _____

GETTING TO KNOW YOU

Is another member of your family or relative a patient in our office? NO YES If so who? _____

How were you referred to our office:

Mailer _____ Newspaper Ad _____ Internet _____ Insurance _____ Drive/Walk by _____ Word of mouth _____

May we have the name of the person who referred you? _____

Person to contact in case of emergency: _____ Phone: _____

Address: _____ City _____ ST _____ Zip _____

Closest relative not living with you: _____ Phone: _____

Address: _____ City _____ ST _____ Zip _____



Consent for Treatment

1. I hereby authorize Dr. Abtahi, her associate(s), or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize Dr. Abtahi / associate(s) to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to Dr. Abtahi's, associate's or designated staff's use and disclosure of any oral written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.. In the event payments are not received by agreed upon dates, I understand that interest or a service charge may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature: _____ Date: _____

Parent/Responsible Party's Signature: _____

Relationship to patient: _____ Date: _____

Office Witness: _____ Date: _____

DENTAL HISTORY

Patient Name _____

Medical Alerts _____

Reason for your visit today? _____

Date of last dental visit: _____ Last Dental Cleaning _____ Last X-rays Taken _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ Phone _____

How often do you have dental exams? _____

How often do you brush? _____ Floss? _____

Have you ever used or are you currently using topical fluoride? No Yes If yes, what kind? _____

What other dental aids do you use? (Interplak, toothpicks, etc) _____

Do you have any dental concerns now? _____

Are any of your teeth sensitive to:

Hot or Cold Yes No
Sweets Yes No
Biting/Chewing Yes No

Do your gums bleed/hurt Yes No

Is there family history of gum disease/tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to get caught in between your teeth? Yes No

Do You:

Clench/grind your teeth while awake or asleep? Yes No

Bit your lip/cheek regularly? Yes No

Hold/chew foreign objects with your teeth?(pencils,pipe,fingernails) Yes No

Mouth breathe while awake/asleep? Yes No

Snore/have sleep disorders Yes No

Smoke/chew tobacco Yes No

Have tire jaws, especially in the morning? Yes No

Have you ever had:

Orthodontic treatment Yes No

Oral Surgery Yes No

Periodontal treatment Yes No

Your teeth ground/bite adjusted Yes No

Bite plate/mouth guard Yes No

Serious injury to the mouth/head Yes No

If so, please describe: _____

Have you experienced:

Clicking/popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Have mouth odor/bad taste Yes No

Frequent cold sores/blisters or other lesions? Yes No

Difficulty in opening /closing the mouth Yes No

Difficulty in chewing Yes No

Headaches/neckaches/shoulder aches? Yes No

Sore Muscles (neck, shoulder)? Yes No

Negative/unpleasant dental experience? Yes No

Explain: _____

Are you nervous/anxious about dental treatment? Yes No

Have you ever been told to pre-medicate prior to dental treatment? No Yes If yes, please explain why _____

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