PATIENT REGISTRATION FORM

PATIENT INFORMATION

Today's Date _____

Patient's Name _____
Last Name First Name Middle Initial

DOB _____ Age _____ Sex □ M □ F

Patient SS# _____

Patient Driver License # _____
If patient is minor we need:
Guardian's Name and DOB _____

Home Address

_____
City State Zip

E-mail _____

Home Phone _____

Work Phone _____

Cell Phone _____
Please check one: □ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for _____ years

Patient's Employer _____

Occupation _____

Emergency Contact
Name _____

Relationship _____

Phone _____

Reference
How did you hear about our office?

_____
If you were referred by a friend, whom may we thank for referring you?

_____

Reason for Today's Visit

_____

DENTAL INSURANCE INFORMATION

Person responsible for this account _____

Relationship to Patient _____

Insurance Co. _____

Group # _____
Is Patient covered by **additional Insurance**? □ Yes □ No

Subscriber's Name _____

DOB _____ SS# _____

Relationship to Patient _____

Subscriber's employer _____

Insurance Co. _____

Group # _____

Assignment And Release
I certify that I, and/or my dependent(s) have insurance coverage with _____
name of insurance company(ies)
and assign directly to Dr. Cheneweth all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above –named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Patient Signature (or Parent, Guardian or Personal Representative)

_____
Print name of Patient, Parent, Guardian or personal Representative

Date _____

Relationship to Patient _____

DENTAL HISTORY

Name of Previous Dentist _____ City/State _____ Phone # _____

Date of last dental visit _____ Reason _____ Date of last complete X-rays _____

Why did you leave your previous dentist? _____

Please check any of the following that apply to you:

□ Bad breath
□ Lip or cheek biting
□ Teeth or fillings breaking
□ Mouth breathing
□ Headaches, ear aches, jaw pain
□ Sensitivity when biting
□ Burning sensation on tongue
□ Clicking or popping jaw
□ Periodontal treatment
□ Dry mouth
□ Loose, tipped or shifting teeth
□ Mouth ulcers, blisters or sores
□ Bleeding, swollen gums
□ Fingernail biting
□ Sensitivity (hot, cold, sweet)
Where? □ UR □ LR □ UL □ LL
□ Grinding teeth
□ Smoking or chewing tobacco
How much? _____(#packs/day)
For how long? _____(years)

If you could change your smile, you would:

□ Make your teeth whiter
□ Make your teeth straighter
□ Close spaces
□ Replace metal filling with tooth colored restorations
□ Repair chipped teeth
□ Replace missing teeth
□ Replace old crowns that don't match
□ Have a smile makeover

On a scale of 1-10 with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Do you have or had any of the following?
□ Dentures □ Partial dentures
□ Braces □ Gum treatments
What is the most important thing to you and your dental visit today?

_____

_____
What is the most important thing to your about your future smile and dental health?

_____

_____

MEDICAL HISTORY

Physician's Name _____ Phone # _____ Date of last visit _____

Have you ever used bisphosphonate medication? Common brand names are □ Fosamax □ Actonel □ Atelvia □ Didronel □ Boniva
Have you ever taken any of the group collectively referred to as "Fen-phen?" These include combinations of Ionimin, Adipex Fastin (brand names of phentermine), Pondimin, (fenfluramine) and Redux (dexfenfluramine).

Please check any of the following that apply to you:

□ AIDS/HIV
□ Anemia
□ Arthritis, Rheumatism
□ Artificial Heart Valves
□ Artificial Joints
□ Asthma
□ Back Problems
□ Blood Disease
□ Cancer
□ Chemotherapy
□ Circulatory Problems
□ Congenital Heart Lesions
□ Cortisone Treatments
□ Cough, Persistent or bloody
□ Diabetes
□ Drug Addiction
□ Emphysema

□ Excessive Bleeding with extractions or surgery
□ Epilepsy
□ Fainting or dizziness
□ Glaucoma
□ Heart Murmur
□ Heart Problems
□ Hepatitis Type (A, B or C ____)
□ Herpes
□ High Blood Pressure
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Low Blood Pressure
□ Mitral Valve Prolapse
□ Nervousness / Depression
□ Pacemaker

□ Psychiatric Care
□ Radiation Treatment
□ Respiratory Disease
□ Rheumatic Fever
□ Scarlet Fever
□ Seizures
□ Stomach Problems
□ Sinus Trouble
□ Skin Rash
□ Stroke
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis (TB)
□ Tumor or growth on head or neck
□ Ulcer
□ Other (please list):

_____

_____

Women: □ Pregnant (mons: □ 0-3, □ 3-6, □ 6-9) □ Due Date _____ □ Are you breast-feeding □ Taking birth control

What medications are you currently taking? List any medications you are currently taking and correlating diagnosis:

_____

_____

Pharmacy Name _____ Phone _____

Are you under a physician's care? For what?

_____

Do you have an allergy to any of the following?

□ Asprin
□ Barbiturates (sleeping pills)
□ Codeine
□ Erythromycin
□ Iodine
□ Latex

□ Local Anesthetic
□ Nitrous oxide
□ Penicillin
□ Sulfa
□ Other

_____

_____