

PATIENT REGISTRATION

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Welcome to our office. We are pleased that you have chosen us to assist you with your dental care. In order to care for you and communicate better, please fill out both sides of this form completely.

1 About You

Today's Date: _____

Name: Mr. Mrs. Ms. Dr. _____

I prefer to be called: _____ (LAST) (FIRST) (MI)

Birthdate: _____ Age: _____ S.S. # _____

Home Address: _____

City: _____ State: _____ Zip: _____

Male Female Single Married Divorced Widowed

Home Phone #: _____ Cell #: _____

Work Phone #: _____ Ext: _____ E-mail: _____

Preferred method of contact: Text Email Phone Call

Employer: _____

Employer's Address (City): _____

Occupation: _____

Is another family member or relative a patient in our office? _____

Name: _____ Relationship: _____

2 About Your Spouse

His/Her Name: _____

Employer: _____ Occupation: _____

Work Phone #: _____ Ext: _____

3 Account Information

Person Financially Responsible for Account: _____

Relation to Patient: _____ S.S. #: _____

Billing Address: _____

Work Phone #: _____ Ext: _____ Home Phone #: _____

Employer: _____

4 Emergency Contact

In the event of an emergency, whom should we contact?

His/Her Name: _____ Relation: _____

Phone #: _____

5 Referral Source

Our practice is fortunate to receive referrals from friends (patients and colleagues) who have been pleased with the services that we provide. Whom may we thank for referring you to us? _____

6 Dental Insurance

Does your employer provide dental insurance? Yes No

Are you eligible for direct reimbursement benefits? Yes No

Ins. Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____

Group #: _____

Name of Policy Holder: _____ Relation: _____

Birthdate of Policy Holder: _____ Insured's S.S. #: _____

Insured's Employer: _____ Date Employed: _____

The services that we provide for you are based on an agreement between you and our office. Your dental insurance relationship constitutes an agreement between you, your employer and your insurance carrier. Please carefully review our policy regarding dental insurance and your responsibilities as the insured. Our dental team is here to help you and will be happy to answer any questions that you may have.

7 Financial Responsibility

I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event of default, I promise to pay legal interest (1 1/2% per month - 18% per annum), together with any collection costs and attorney fees as may be required to effect collection of this note.

I hereby authorize payment of my dental insurance benefits directly to Drs. Hunt & Hunt, P.A. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services and I understand that I am financially responsible for payments in full of all accounts by signing this agreement.

Date: _____ Relationship to patient: _____
Signature of patient, parent, or guardian

Date: _____ Relationship to patient: _____
Signature of guarantor of payment/responsible party

MEDICAL HISTORY

Have you been under the care of a physician during the past two years? Yes No

If yes, for what? _____

Physician's name: _____ Phone: _____

Are you taking, or have you ever taken bisphosphonates such as Fosamax, Boniva, Actonel Atelvia, Reclast? Yes No

Are you currently taking any prescription or over the counter medications? Yes No

If yes, please list name and dosage _____

Are you aware of having an allergic or adverse reaction to any medication or substance? Yes No

If yes, please describe _____

Please indicate which of the following you have had, or have at present. Circle Y for Yes, N for No.

Heart Attack Y N	Diabetes..... Y N	Cancer Therapy..... Y N
Heart Surgery Y N	Tuberculosis Y N	Psychiatric/Psychological Care..... Y N
Chest Pain Y N	Asthma Y N	Kidney Trouble Y N
Congenital Heart Disease..... Y N	Liver Disease Y N	Tumors Y N
Heart Murmur Y N	Arthritis, Rheumatism..... Y N	A.I.D.S. Y N
Mitral Valve Problems Y N	Cortisone Medicine..... Y N	H.I.V. Positive Y N
Artificial Heart Valve Y N	Nervous/Anxious Y N	Thyroid Problems..... Y N
Rheumatic Fever Y N	Neurological Disorders..... Y N	Blood Disorders Y N
Heart Pacemaker Y N	Allergies or Hives Y N	Cold Sores/Fever Blisters Y N
High Blood Pressure Y N	Epilepsy or Seizures..... Y N	Indigestion..... Y N
Swollen Ankles Y N	Stroke Y N	Reflux Y N
Ulcers Y N	Sinus Trouble Y N	Sleep Apnea Y N
Hepatitis Y N	Fainting or Dizzy Spells..... Y N	

Do you have or have you had any disease, condition or problem not listed above? Yes No

If yes, describe _____

Have you ever been told that you require premedication with antibiotics prior to dental treatment? Yes No

Have you ever had a joint replacement? Yes No

Date _____

Do you have latex sensitivity? Yes No

Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

COMMENTS

CONSENT FOR TREATMENT

I understand that the information contained in the dental and medical histories is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective health care provider or agency who may release such information to you. I will notify Drs. Hunt and Hunt of any changes in my health or medication. The undersigned hereby authorizes Drs. Hunt, Hunt, and Lestini to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize Drs. Hunt, Hunt, and Lestini to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

DENTAL HISTORY

Welcome to our office. So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

Previous Dentist _____ Period of Treatment _____

Address _____ Phone _____

Date of last dental visit _____

Frequency of dental care: _____ Regular _____ Periodic _____ Emergency

How would you rate your home care? _____ Good _____ Fair _____ Poor

What is your immediate dental concern? _____

Please circle Yes or No. If yes, please fill in details.

YES NO Are you presently experiencing any dental pain or discomfort? _____

YES NO Have you ever had an upsetting dental experience? _____

YES NO Do you feel nervous about receiving dental treatment? _____

YES NO Is any part of your mouth sensitive to temperature, pressure, or food/drink? _____

YES NO Do you have an unpleasant taste or odor in your mouth? _____

YES NO Do your gums hurt or bleed when you brush or floss? _____

YES NO Have you ever been told you have gum disease? _____

YES NO Have you been treated for gum disease? When? _____

YES NO Have your parents experienced gum disease? _____

YES NO Have you lost any teeth? From what cause? _____

YES NO Have you noticed any loose teeth or change in your bite? _____

YES NO Does food catch between your teeth? Where? _____

YES NO Do you have any pain or soreness around your eyes or ears or other parts of your face? _____

YES NO Are you aware of stiff neck muscles? How often? _____

YES NO Do you ever awaken with an awareness of sore teeth or jaw joints? How often? _____

YES NO Are you aware of clenching and/or grinding your teeth? _____

YES NO Are you aware of your jaw clicking or popping while eating or yawning? How often? _____

YES NO Do you have difficulty opening/closing your mouth? _____

YES NO Do you have "tension" headaches? How often? _____

YES NO Have you ever had your bite adjusted? When? _____

YES NO Have you ever worn a bite splint or night guard? When? _____

YES NO Have you ever experienced a serious injury to your head or mouth? _____

YES NO Have you ever had orthodontic treatment? When? _____

YES NO Have you ever had oral surgery? When? _____

YES NO Do you smoke or chew tobacco? _____

YES NO Do you snore? _____

YES NO Is your home water supply fluoridated? _____

YES NO Are you dissatisfied with the appearance of your teeth/smile? Why? _____

YES NO Do you think your dental disease is active? _____

YES NO Do you want to learn to control your dental disease and retain your teeth? _____

YES NO Are you deeply concerned about the finances required to return your mouth to excellent health? _____

Why have you chosen our office for your dental care? _____