New Patient Registration

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Patient's Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Sex: Male/Female Marital Status: Single/Married/Divorced/Other

Social Security #: _____ Driver's License: _____ State: _____

Home Address: _____ City, State, Zip: _____

Telephone1: _____ mobile/home/work Email: _____

Telephone2: _____ mobile/home/work Preferred method: □Email □Phone □Text □Mail

If applicable: Spouse's Name: _____ Spouse's Telephone: _____

Emergency Contact: _____ Relationship: _____ Tel: _____

Pharmacy: _____ Cross Street: _____ Tel: _____

How did you hear about us? □ Referral □ Google □ Yelp □ Yahoo □ Ins Website □ Angie's List □ Dr.Oogle □ Live nearby □ Drive by

□ If other, specify _____ if referral, who may we thank: _____

Dental Insurance Information: *(Please let us know if you have secondary insurance)*

Policyholder Name:		Insurance Co.	
Policyholder SSN:		Member ID #	
Policyholder Birthday:		Insurance Group #	
Relationship to Policyholder:	□Self □Spouse □Child □Other	Insurance Phone #	
Employer Name		Employer Address	

Broken Appointment Policy:

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion. So that the dentist, our staff, and our other patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that **failure to give sufficient warning to keep a scheduled appointment, 48 hours advanced notification, will result in a $50.00 fee being charged**. That charge which is in accordance with our dental office's broken appointment policy for all of our patients is to be paid prior to the scheduling of any new appointments. **Patient Initials:** _____

Insurance and Payment Agreement:

Our office will file insurance claims at no charge. It is the patient's responsibility to provide us current insurance information. Insurance limitations and regulations vary with all insurance plans. As a courtesy, **our staff will provide you an estimate; however, we do not guarantee your eligibility and coverage**. Therefore, if your insurance plan denies a service, you are responsible for the complete charge. I agree to pay the fees for any dental care provided by Summer Smiles Dental and Orthodontics. A finance charge of 18% annually may be applied to any overdue balance remaining after 90 days. In the event that collection procedures are necessary to collect the account, I agree to pay any attorney's fee, court costs, or collection agent fees. **Patient Initials:** _____

Patient's Signature: _____ Date: _____

(Parent/Guardian signature if patient is a minor)

Health History

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Name: _____

Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the front office.

Dental Information

For the following questions, please mark (X) if you have or have not had any of the following conditions or problems.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐

If yes, please describe

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

Date of last dental x-rays:

	Yes	No	DK
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Do you have dental anxiety?	☐	☐	☐

What was done at that time?

If applicable, reason for change of dental provider:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

For the following questions, please mark (X) to your applicable status.

Date of last physical exam:

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name and specialty of the physician making the recommendation: Phone:

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

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Health History - Continue

Name: _____

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Medical Information

Please mark (X) to your applicable status/condition. Check DK, if you don't know the answer.

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			

WOMEN ONLY Are you:

	Yes	No	DK
Pregnant?	☐	☐	☐
Number of weeks? _____			
Taking birth control or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Other drugs: _____			

	Yes	No	DK
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____			

Medical Alerts - pre-med

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐

Congenital heart disease (CHD)

	Yes	No	DK
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Medical History

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Headaches/migranes	☐	☐	☐
G.E. Reflex/heartburn	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Please list any disease, condition, or problem not listed above that I should know about:

Sleep History

	Yes	No	DK
Has anyone ever told you that you snore?	☐	☐	☐
Has anyone ever told you that you stopped breathing during sleep?	☐	☐	☐
Do you wake up frequently at night?	☐	☐	☐
Do you experience heartburn or reflex symptoms during sleep?	☐	☐	☐
Sleep talking	☐	☐	☐
Acting out dreams	☐	☐	☐
Bedwetting	☐	☐	☐
Memory problem	☐	☐	☐
Difficulty w/concretration	☐	☐	☐
Night sweats	☐	☐	☐
CPAP for sleep	☐	☐	☐
Oral appliances for sleep	☐	☐	☐

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

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Consent for Use and Disclosure of Health Information

Patient Name: _____ Social Security #: _____

Please list the names of ALL the people you authorize us to release your health information to, including copies of your records if needed: _____

Patient Consent:
By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practice. If we change our privacy practices, we will issue we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice, at any time by contacting us.

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation of this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

Patient's Signature: _____ Date: _____
(Parent/Guardian signature if patient is a minor)