PATIENT REGISTRATION

Crystal Falls Dental

Date____________________

Patient Name ____ Birth date ______________________ Age__________

First Middle Last

SS#____________________DL#_________________ Occupation ____________________________Work # (____)___________

Marital Status: Single___ Married___ Divorced___ Widowed___ Spouses Name:_________________ Work # (____)___________

Home Address____City/St_____________________ Zip _____________

Home Number (____)______________________ Cell Phone (____)______________________ Work #(____)________________

Fax #(___)__________________________________ E- Mail Address ____

Employer Name and Address ____

Person Responsible for Account__________________________________Relationship ________________________________

Social Security # ______________________________DL#___________Home # (___)______________________________

Home Address (if different)____Zip__________________

Employer & Address____

Occupation____Work # (___) ______________________________

Do you have Dental Insurance? Yes _______ No______ With Whom?____

Circle yes or no to the following questions:

1. Are you presently under the care of a physician?	Yes	No
2. Have you ever had high/low blood pressure?	Yes	No
3. Has a physician ever said you had heart trouble? (ex: Artificial heart valve, Heart attack, Pace maker, Angina Pectoris)	Yes	No
4. Do you have Mitral Valve Prolapse or Congenital Heart Defect?	Yes	No
5. Have you ever had abnormal bleeding following a cut or extraction?	Yes	No
6. Have you ever had an anesthetic (either local or general)?	Yes	No
7. Has a physician or dentist ever said you had a tumor or cancer?	Yes	No
8. Are you taking any osteoporosis medications?	Yes	No
9. Are you allergic to Penicillin, Novocain or any other medicine?	Yes	No
If so, what? ______________________________		
10. Is the patient allergic to anything other than medicine? (e.g. latex or metals)?	Yes	No
If so, what? ______________________________		

Do you have or ever had:

1. Rheumatic fever?	Yes	No
2. Rheumatic heart disease?	Yes	No
3. Anemia, leukemia or low platelets	Yes	No
4. Epilepsy or convulsions?	Yes	No
5. Asthma or hay fever?	Yes	No
6. Tuberculosis	Yes	No
7. Diabetes? How long	Yes	No
8. Kidney trouble?	Yes	No
9. Liver trouble or jaundice?	Yes	No
10. Thyroid trouble or goiter?	Yes	No
11. Syphilis?	Yes	No
12. Fainting or dizziness?	Yes	No
13. Glaucoma?	Yes	No
14. Arthritis?	Yes	No
15. HIV AIDS?	Yes	No
16. Stroke?	Yes	No
17. Stomach ulcer?	Yes	No
18. Heart murmur?	Yes	No
19. Prostate trouble?	Yes	No
20. Hepatitis A, B, C or D	Yes	No
21. Eczema or hives?	Yes	No
22. Psychiatric treatment?	Yes	No
23. Are you pregnant?	Yes	No
24. Alcohol abuse	Yes	No
25. Recreational Drug use	Yes	No
26. Blood Transfusion	Yes	No
27. Emphysema	Yes	No
28. Frequent Headaches	Yes	No
29. STD's	Yes	No
30. Chemo or Radiation Therapy	Yes	No
31. Joint Replacement	Yes	No
32. Fever Blisters or Shingles	Yes	No
33. Colitis	Yes	No
34. Facial Surgery	Yes	No
35. Difficulty Breathing	Yes	No
36. Sickle Cell Disease	Yes	No
37. Seizures	Yes	No

Are you now taking:

1. Drugs for high blood pressure?	Yes	No
2. Drugs for sleep?	Yes	No
3. Cortisone, steroids or ACTH?	Yes	No
4. Anticoagulants or blood thinner?	Yes	No
5. Tranquilizers or sedatives?	Yes	No
6. Antibiotics?	Yes	No
7. Insulin?	Yes	No
8. Have you ever taken Fen-Phen?	Yes	No
9. Others?	Yes	No

10. List any questions:____________________________________

____

11. Have you been under the care of a physician for any major illness or injury other than those noted above. If so, list.

____

I Understand That Payment Is Due At Time Of Service.

I will pay today by: ❑ CASH ❑ CHECK ❑ CREDIT CARD

❑ I would like to open a 90 day interest free account with Crystal Falls Dental, based upon my credit being approved.

I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

Signature_________________________________**Date**__________

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.

Patient Information

Name____

Height __________ Weight ____________

Gender: ___Female ___Male

Emergency Contact __________________________ Phone # _______________ Relation ___________________

Nearest Relative Not Living With You__________________________________Relationship_________________

Phone (___) _________________

Primary Physician____________________________________ Phone #____________________________________

Please list any medications you are currently taking:

____

____

Insurance Information

Primary Dental Carrier:

Subscriber __________________________ Social Security # _________________ DOB ____________________

Employer __________________________Insurance Company _______________________________________

Insurance Company Phone # _____________________________Group # ________________________________

Subscriber's Relation to Patient ___________________________

Insurance Authorization

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature ____ Date _____________________

Guardian Signature ____ Date______________________

Relation to Patient _____________________

Patient Agreement

At Crystal Falls Dental, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation.

We work with thousands of insurance companies. Although we can maintain computerized histories of payment by a given company, fees do change regularly; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. As a courtesy, we bill your insurance for you. We are a 'fee for service' establishment, so payment will be due at the time of treatment.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Signature____Date____________________________

Guardian Signature____ Date____________________________

Dental History

How did you hear about us? ____

*If referred, who can we thank for your referral?*____

What is the reason for today's visit? ____

What would you like to change about your smile? ____

Why did you leave your last dentist? ____

When was your last dental visit? ____

What did you like *most* about your last dentist? ____

Do your gums bleed while brushing or flossing? ____

Do you grind your teeth? ____

Do you snore or does your significant other snore? ____

Have you ever had prolonged bleeding after an extraction or surgery? _____________________________

Are you currently having dental problems? ____

What are your dental concerns? *Check as many as are applicable:*

___Pain avoidance
___Appearance
___Losing teeth
___Gums/Periodontal Disease
___Cavities
___Oral Cancer
___Wasting/Exceeding Dental Insurance Limits
___Your general health
___Routine check up
___Cleaning

Other ____

Please note if you are interested in any of the following:

___ Invisalign – Clear Braces
___ Implants
___ Bad Breath Treatment
___ Closing Gaps in Teeth
___ 6 Month Braces
___More Attractive Smile
___ Veneers / Lumineers
___ Fixing Chipped Teeth
___ Replacing Missing Teeth
___ Preventing Cavities

How would you like to receive appointment reminders? *Check as many as are applicable:*

___ Text ___ Email ___Phone Call

Which TV show do you prefer?

___HGTV ___ESPN ___Cartoon Network ___Travel Channel ___TLC ___E! TV ___Lifetime
___VH-1 ___Food Network ___Bravo ___Discovery Channel ___History Channel
___Other

Treatment Authorization

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary as advisable; including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

I also understand that payment for all treatment and services rendered are my responsibility.

Patient's Signature: ____ Date: ______________________

Guardian Signature: ____ Date: ______________________