PATIENT REGISTRATION

Welcome to Prosper Smiles Family Dentistry!
To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name _____Preferred name _____

If minor, parents names _____ Date of Birth_____Sex_____

Home phone _____ Work phone _____Cell Phone_____

Email address_____

Mailing address _____ City _____State _____ Zip _____

Driver's License #:_____State:_____ SS#:_____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Primary Dental Insurance Co._____

ID#_____Group number_____Phone Number_____

Secondary Dental Insurance Co._____

ID#_____Group number_____Phone Number_____

Subscriber's Name_____DOB_____SS#_____

Relationship to Subscriber_____

EMERGENCY CONTACT INFORMATION

Name_____Relationship_____Phone #_____

Physician Name_____Phone #_____Date of last visit_____

Name of Previous Dentist_____Phone #_____Date of last visit_____

Reason for changing dentists_____

FINANCIAL AGREEMENT: I acknowledge and authorize that this office may release my information to my insurance company and I also authorize my insurance company to pay directly to this office benefits accruing under my insurance policy. I accept financial responsibility for myself and/or the above named patient (if legal guardian). I understand that the policy of this office is to make financial arrangements in advance and that payment must be made prior to services being rendered. If sent to collections, I agree to pay all related fees and court costs. Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible. I agree to pay finance charges of 1.5% per month (18%APR) on any balance 90 days past due. I understand that there is a $25 charge for broken appointments with less than 24 hours notice. Treatment plans may change, and I will be responsible for the dental work actually done.

Signature of patient (or parent) _____ Date _____

DENTAL & MEDICAL HEALTH HISTORY

PATIENT NAME:_____**DATE OF BIRTH**_____
REASON FOR TODAY'S VISIT:_____

Are you nervous about seeing a dentist? ❑ yes ❑ no If yes, please tell us why:_____
How often do you brush?_____ Do you floss? ❑ yes ❑ no How often?_____

Please check any that apply:

- ❑ I clench or grind my teeth during the day or while sleeping
- ❑ My gums bleed while brushing or flossing
- ❑ I avoid brushing part of my mouth due to pain
- ❑ I have pain in my jaw
- ❑ I like my smile
- ❑ My gums feel tender or swollen
- ❑ I have problems eating
- ❑ I have had a facial or jaw injury
- ❑ I want my teeth straighter
- ❑ I want my teeth whiter

What are you dental priorities?_____

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina (chest pain & shortness of breath)
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or heart valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease and/or Dialysis
- ❑ Ulcers
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Stroke
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Thyroid problems
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Sexually Trasmitted Disease
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Do drink alcohol? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin, Acetaminophen, or Ibuprofen
- ❑ Reaction to metals
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (i.e. blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine-Bisphosphonate
- ❑ List any other medications including over-the-counter and herbal supplements:
  _____
  _____

Do you require premedication antibiotics prior to dental procedures? ❑ yes ❑ no

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives
- ❑ Nursing

Do you have any disease, condition, or problem not listed above?_____

I hereby certify that I have read and understand the above questions and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

Signature of patient (or parent) _____Date _____