PATIENT REGISTRATION

PLEASE PRINT **Today's Date** _____

Name _____ Birthdate _____ Age ____

Address _____ ☐ Married ☐ Single ☐ Child ☐ Other

City, State, Zip _____ Social Security # _____

Phone #s: Home _____ Work _____

Cell _____ Email _____

Employer _____ Occupation _____

Spouse/Parent/Guardian's Name _____

Employer _____ Work phone _____

College student? School name _____ City, State _____

Whom may we thank for referring you? _____

Emergency contact _____ Phone # _____

DENTAL INSURANCE

Name of Insured _____ Birthdate _____

Relationship to Patient _____ Social Security # _____

Employer _____ City, State, Zip _____

Insurance Company _____ Group # _____

Do you have additional Dental Insurance? ☐ Yes ☐ No If Yes, complete the following:

Name of Insured _____ Birthdate _____

Relationship to Patient _____ Social Security # _____

Employer _____ City, State, Zip _____

Insurance Company _____ Group # _____

DENTAL HISTORY

Please circle Yes or No. Your answers are for our records only and will be considered confidential.

Yes No Do you clench or grind your teeth during day or night?

Yes No Do you feel any teeth are loose?

Yes No Have you noticed any tenderness or swelling in your gums?

Yes No Do you avoid either side while chewing or brushing? Which side? _____
Why? _____

Yes No Do your gums bleed during or after brushing?

Yes No Have you ever taken, or are you currently taking osteoporosis medication?

Yes No Have you had any peridontal (gum disease) treatments?

Yes No Have you had a complete dental examination, including a complete set of dental x-rays (16-18 films) within the last 3 years? Date of last visit _____ Purpose _____

Yes No Have you had any serious trouble associated with any previous dental treatment?
If so, explain. _____

Yes No Are you happy with the appearance of your teeth?

Yes No Would you like to discuss options to whiten your teeth?

What is your primary dental concern? _____

_____

PLEASE COMPLETE OTHER SIDE

HEALTH HISTORY

Please circle Yes or No. Your answers are for our records only and will be considered confidential.

1. Date of last physical exam _____

Yes No 2. Are there any changes in your health in the past year?

Yes No 3. Are you now under the care of a physician? Physician's name? _____
If so, what is the condition being treated? _____

4. Do you have or have you had any of the following diseases or problems?

Yes No A. Damaged heart valves or artificial heart valves, including heart murmur
Yes No B. Congenital heart lesions
Yes No C. Cardiovasclar disease (heart trouble, heart attack, heart failure, high blood pressure)
Yes No D. Joint replacement or implants of any kind
Yes No E. Sinus trouble
Yes No F. Diabetes
Yes No G. Hepatitis, jaundice or liver disease
Yes No H. Stomach ulcers
Yes No I. Tuberculosis
Yes No J. Epilepsy
Yes No K. Psychiatric problems.
Yes No L.. Cancer
Yes No M. AIDS or other immuno suppressive disorder

Yes No 5. Do you have any disease, condition, or problem not listed above that you think I should know?
If so, explain _____

Yes No 6. Have you had surgery, radiation or drug treatment for a tumor, growth or other condition?

Yes No 7. Do you take pre-medication for dental appointments? If so, what? _____

Yes No 8. Are you taking any drugs or medicaton? If so, what? _____
_____

9. Are you taking any of the following?

Yes No A. Anticoagulants (blood thinners)
Yes No B. Aspirin
Yes No C. Oral contraceptive

Yes No 10. Are you allergic to any medications? If so, what? _____

Yes No 11. If female, are you pregnant?

Authorization:
I understand that I am financially responsible for all charges whether or not paid by insurance.
I authorize my insurance company to pay to Collins and Montz, D.M.D., P.A., all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.

Payment is due in full at time of treatment unless prior arrangements have been approved.

SIGNATURE of patient or parent/guardian _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the dentist or staff responsible for any errors or omissions that I have made in the completion of this form.

_____ _____

Signature of Patient or Parent/Guardian Date