

# PATIENT REGISTRATION

What do you like to be called? \_\_\_\_\_

<b>Patient's Name</b>	Sex: M F	Birthdate	Age	Today's Date
Home Address		City	State	Zip
Please Circle One: Single, Married, Separated, Widow		Occupation	Home Phone Number	
Your Employer	How Long Employed	Your Soc Sec. #	Work Phone	
Are you a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>If patient is minor we need: Mother's Birthdate:</i>	<i>Father's Birth Date</i>	
<b>Person responsible for account</b>		Driver's license number		
Name of spouse (Parent if minor)		E-mail address	Cell Phone	
Spouse's (parent's) employer		Spouse's Soc. Sec. #	Work phone	

<b>How did you hear about our office?</b>	<b>EMERGENCY INFORMATION</b>
Reason for this visit	Name, Address, & telephone of _____ A Relative Not living with you.

DENTAL INSURANCE INFORMATION (Primary Carrier)			If you have dual insurance coverage, complete this for the second coverage		
Insured's name	DOB	SS#	Insured's name	DOB	SS#
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	Local #		Group #	Local #	

## OUR PLEDGE TO YOU

- We will respect your time.
- We will provide you with the information and attention you need to make intelligent decisions.
- We will be skilled and gentle.
- You will leave here feeling confident that you were well taken care of.
- You will receive individualized attention and feel important.

## YOUR PLEDGE TO US

### KEEPING YOUR APPOINTMENTS

We understand that a situation may arise that could force you to postpone your treatment. Please understand that such changes affect not only your dentist but our ability to help other patients. Dr. Tennant's time, as well as that of our staff, is a precious commodity, and we request your courtesy and concern. Please respect our time. A \$45 administrative fee will be charged to patients that change or cancel their appointment within 48 hours of their scheduled visit.

### COMPLIANCE/COOPERATION

You are expected to follow our instructions closely in order to reach your goals.

### FOR THOSE WHO SELF PAY...

Payment is due in full at the time of service. We prefer checks and also accept Visa, Master Card, cash and payment thru our outside financing partner (Capital One).

### FOR THOSE WHO USE INSURANCE...

- You will not receive benefits from a DMO or HMO plan for services in this office. Your policy must give you the freedom to choose your dentist in order to receive benefits at this office. You will receive benefits from a PPO plan although we are not a network provider with any PPO plan.
- We recommend that you submit your insurance. We can assist with your forms.
- As a service to you, our office can submit your insurance for you. Remember that it is YOUR insurance and all charges you incur are your responsibility regardless of your insurance coverage. We are NOT experts on your insurance.
- At the time of service, you are expected to pay your portion of the total fee. We do not guarantee what your insurance company will pay; we estimate the amount they usually pay.
- We will do what we feel is in your best interest, not what your insurance company thinks you need or is "necessary". Many times carriers tell patients our procedures are not "necessary". We will not enter into disputes with your insurance company over any claim.
- You are responsible for payment regardless of your insurance company's determination of "usual and customary" fees.
- Insurance payments are normally received within 30 days. If your insurance company has not made payment within 40 days, you will be responsible for paying the full amount at that time. Our office will continue to cooperate with your insurance company and support you in getting your benefits.

I have read, understand and agree to the above. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# DENTAL HISTORY

**Please check any of the following problems that apply to you.**

- Sensitivity (hot, cold, sweet)   
Where? UR LR UL LL
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

**Do you have or have you had any of the following?**

- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

**Please share the following dates:**

- Your last cleaning \_\_\_\_\_ / \_\_\_\_\_
- Your last oral cancer screening \_\_\_\_\_ / \_\_\_\_\_
- Your last complete X-Rays \_\_\_\_\_ / \_\_\_\_\_

**Name of Previous Dentist** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**What is the most important thing to you about your future smile and dental health?** \_\_\_\_\_

**If you could whiten your teeth for a cost anyone could afford, would you do it?** Y N

**Do you smoke or use chewing tobacco?** Y N  
How much? For how long?

**If I could change my smile, I would:**

- Make them whiter
- Make them straighter
- Close spaces
- Replace black metal fillings with tooth colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

**On a scale of 1 – 10, with 10 being the highest rating:**

- How important is your dental health to you?  
1 2 3 4 5 6 7 8 9 10
- Where would you rate your current dental health?  
1 2 3 4 5 6 7 8 9 10
- Where do you want your dental health to be?  
1 2 3 4 5 6 7 8 9 10

**Why did you leave your previous dentist?** \_\_\_\_\_

**What is the most important thing to you about your dental visit today?** \_\_\_\_\_

# MEDICAL HISTORY

**Please check any of the following that apply to you:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Drug Addiction             | <input type="checkbox"/> HIV Positive           | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Allergies (Seasonal)   | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Rheumatism        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Excessive Bleeding         | <input type="checkbox"/> Jaw Joint Pain         | <input type="checkbox"/> Scarlet Fever     |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Heart Conditions           | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart Lesions (Congenital) | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Heart Surgery              | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Hepatitis A                | <input type="checkbox"/> Phen Fen (1 month +)   | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Hepatitis B                | <input type="checkbox"/> Pregnant Currently     | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hepatitis C                | <input type="checkbox"/> Radiation (head/neck)  |  |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Respiratory Problems   |  |

**Do you have any of the following allergies?**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Aspirin          | <input type="checkbox"/> Codeine      |
| <input type="checkbox"/> Darvon           | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Nitrous Oxide    | <input type="checkbox"/> Valium       |
| <input type="checkbox"/> Percodan         | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Tetracycline     | <input type="checkbox"/> Other        |

Patient Signature (Parent of Child) \_\_\_\_\_

**Are you under a physician's care? What for?** \_\_\_\_\_

**Are you taking any medications? What?** \_\_\_\_\_

**Family Physician** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

Date \_\_\_\_\_ Dentist Signature \_\_\_\_\_