Dental Registration and History

Reviewed by: ______________________ Date: ________
Reviewed by: ______________________ Date: ________

1 Patient Information

Patient ______________________ Address ______________________
Date of Birth ______________________ City ____________ State ____________ Zip ________
❑ Male ❑ Female ❑ Married Name of Spouse ______________ Social Security # ______________
Employer ______________________ Occupation ______________________
If you are completing this form for another person, what is your relationship to that person? ______________
Home # ______________ Work # ____________ Spouse's Work # ____________
Cell Phone # ______________ Email Address ______________________
Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________ Relationship ______________________
Home Phone ______________________ Work Phone ______________________
Whom may we thank for referring you to us? ______________ If patient is a child, give parent's name ______________

2 Dental History

Former Dentist ______________________
Date of Last Dental Visit ______________________
Check Yes or No if you have had any of the following:

Bad Breath	❑ Yes	❑ No
Bleeding Gums	❑ Yes	❑ No
Cigarette, Pipe or Cigar Smoking	❑ Yes	❑ No
Clicking or Popping Jaw	❑ Yes	❑ No
Dry Mouth	❑ Yes	❑ No
Food Collection Between Teeth	❑ Yes	❑ No
Grinding Teeth	❑ Yes	❑ No
Gums Swollen or Tender	❑ Yes	❑ No
Jaw Pain or Tiredness	❑ Yes	❑ No
Loose teeth or broken fillings	❑ Yes	❑ No
Orthodontic Treatment	❑ Yes	❑ No
Pain Around Ear	❑ Yes	❑ No
Periodontal (Gum) Treatment	❑ Yes	❑ No
Sensitivity to Cold	❑ Yes	❑ No
Sensitivity to Heat	❑ Yes	❑ No
Sensitivity to Sweets	❑ Yes	❑ No
Sensitivity When Biting	❑ Yes	❑ No
Sores in your Mouth	❑ Yes	❑ No

Have you had any serious trouble with previous dental treatment?
____

What would you like to change about your smile? ______________
____

3 Health History

Are you taking any of the following medicines: (CIRCLE) NONE

Antibiotics or Sulfa Drugs	Insulin	Blood Thinners: Coumadin, Plavix,
High Blood Pressure Medications	Aspirin	Other: ______________
Cortisone (Steroids)	Digitalis or Heart Medications	Osteoporosis/Bone Density Medication:
Tranquilizers	Nitroglycerin	Fosamax, Boniva
Antihistamines	Oral Contraceptive or Hormone Therapy	Other ______________
Oral Medication for Diabetes	Please List All Other ______________	

Are you allergic or have you reacted adversely to any of the following: (CIRCLE) NONE

Local Anesthetics	Latex	Epinephrine
Penicillin	Aspirin	Other ______________
Sulfa Drugs	Iodine	
Barbituates, Sedative or Sleeping Pills	Codeine or Other Narcotics	

3 Health History Continued

Have you had any of the following:

	Yes	No
Rheumatic Fever ______	❑ Yes	❑ No
Heart Murmur ______	❑ Yes	❑ No
Mitral Valve Prolapse ______	❑ Yes	❑ No
Cardiovascular Disease/Heart Trouble ______	❑ Yes	❑ No
High Blood Pressure ______	❑ Yes	❑ No
Low Blood Pressure ______	❑ Yes	❑ No
Arthritis ______	❑ Yes	❑ No
Hepatitis/Jaundice ______	❑ Yes	❑ No
Tuberculosis ______	❑ Yes	❑ No
Diabetes ______	❑ Yes	❑ No
Anemia ______	❑ Yes	❑ No
Veneral Disease ______	❑ Yes	❑ No
AIDS/HIV Positive ______	❑ Yes	❑ No
Kidney Disease ______	❑ Yes	❑ No
Do you have asthma or hay fever? If so, which one ______	❑ Yes	❑ No
Do you ever have hives or skin rash? ______	❑ Yes	❑ No
Have you had fainting spells or seizures? ______	❑ Yes	❑ No
Have you ever had prosthetic replacement surgery? ______ (Heart Valve, Hip or Knee Joint)?	❑ Yes	❑ No
Do you have a cardiac pacemaker? ______	❑ Yes	❑ No
Do you have sinus trouble? ______	❑ Yes	❑ No
Have you ever had surgery or x-ray treatment for a tumor, growth or other condition of the head or neck? ______	❑ Yes	❑ No
Physician's Name and Address ______		
Are you in good health? ______	❑ Yes	❑ No
Has there been any change in your general health within the past year? ______	❑ Yes	❑ No
Are you being treated by a physician now for any condition? ______	❑ Yes	❑ No
Do you have any disease, condition or problems not listed above about which we should be aware? ______	❑ Yes	❑ No
If so, explain ______		

WOMEN

	Yes	No
Are you pregnant? ______	❑ Yes	❑ No
Are you nursing? ______	❑ Yes	❑ No

Payment for all services are the responsibility of the patient, as we are a fee for service office.
I agree to pay all copays, deductibles and noncovered services as determined by my insurance company. I understand that there is a return check fee applied to every returned check. I agree to pay an additional 28% of the amount owed as a collection fee for all accounts not paid in the time stated on the final monthly statement. I authorize the release of information concerning my treatment concerning my treatment by Dr.'s Belton & Schrimper to my insurance company. I also authorize the release of any of my dental information to any specialist I may be referred to. I understand verification of eligibility is not a guarantee of payment as stated by my insurance company. I authorize payment of my insurance benefits to Dr.'s Belton & Schrimper.

Signature of Patient or Legal Guardian ______ **Date** ______

4 Dental Insurance

Do you have dental Insurance? Yes No

If so, Insured Name ______ Insured Soc. Sec. # ______

Employer Providing Ins. ______ & Address ______

Insurance Company Name ______ & Address ______

Policy/Group Number ______ Insured Birth Date ______

Broken Appointment Policy

When you schedule a dental visit with us please make every attempt to make your appointment. This time is set aside specifically for you and no one else. We do not "double book" as many offices do. Prior to your appointment you will receive a reminder phone call, and a text message to remind you of your appointment. So when cancellations without notice happen—sometimes as little as an hour ahead of time—we feel like we have been stood up for a very important appointment that you made with us.

Of course, we understand that true emergencies do occur and we will be understanding as much as possible.

We have always had a 2 BUSINESS DAY cancellation policy and would be grateful if you could please give us at least 48 hour notice. Please note our office is closed on Fridays. If you fail to give us the advanced notice, fail to show for your confirmed appointment, or you arrive excessively late, then our office reserves the right to enforce our broken appointment policy. The Broken Appointment Fee is $50.

This may sound harsh, but please understand that if you have 2 or more broken appointments, we reserve the right to release you as a patient and ask that you seek treatment at another dental practice. We will transfer records an do everything we can for you to facilitate a smooth transition for dental care.

By signing below, you have read, and understand this agreement.

Your understanding in this policy is greatly appreciated. Thank you!

Patient Signature: ____

Print Patient Name: ____

Date: ____