Patient Registration

FORM DATE: ___/___/_____

Patient ID: _____ Chart ID: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐

First Name **Middle Initial** **Last Name**

Family Physician Name

Responsible Party (If someone other than patient)

Name

Patient Information

Street Address

City State Zip

Home Phone ( ) - Work Phone ( ) - Cell Phone ( ) -

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ___/___/_____ Social Security Number _____-_____-_____

E-mail Spouse Name

☐ Employed Student Status ☐ Full Time ☐ Part Time Height: ☐ Feet ☐ Inches

☐ Allow Spouse to Review Records

Family Dentist

Medical Insurance Information

Primary Medical Insurance Information

First Name of Insured: Last Name Middle Initial

Policy/Group No. Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID No. Insured Birth Date ___/___/_____ Plan Name

Employer Ins. Company

Insured Address if different than patient's

Street Address Street Address

City, State, Zip City, State, Zip

Patient Signature: Date:

Secondary Medical Insurance Information

First Name of Insured: Last Name Middle Initial

Policy/Group No. Insurance Plan or Program Name

Insured Birth Date ___/___/_____ Sex: ☐ Male ☐ Female Insurance ID No.

Employer Ins. Company

Insured Address if different than patient's

Street Address Street Address

City, State, Zip City, State, Zip

Patient Signature: Date:

Medical History Questionnaire

OFFICE USE
Patient ID:

NAME: _____

FORM DATE: ___/___/_____

DATE OF BIRTH: ___/___/_____

Allergens

- ☐ No known allergens
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Plastic
- ☐ Sedatives
- ☐ Sleeping pills
- ☐ Sulfa drugs

Current Medications

Medicine	Dosage/Frequency	Reason

Other

Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	Acid reflux	☐	☐	
☐	Anemia	☐	☐	
☐	Atherosclerosis	☐	☐	
☐	Arthritis	☐	☐	
☐	Asthma	☐	☐	
☐	Autoimmune disorder	☐	☐	
☐	Bleeding easily	☐	☐	
☐	Blood pressure - High	☐	☐	
☐	Blood pressure - Low	☐	☐	
☐	Bruising easily	☐	☐	
☐	Cancer	☐	☐	
☐	Chemotherapy	☐	☐	
☐	Chronic fatigue	☐	☐	
☐	Chronic pain	☐	☐	
☐	COPD	☐	☐	
☐	Coronary heart disease	☐	☐	
☐	Current pregnancy	☐	☐	
☐	Depression	☐	☐	
☐	Diabetes	☐	☐	
☐	Difficulty sleeping	☐	☐	

Patient Signature: _____ Date: _____

Medical History

Significant	Medical Condition	Current	Never	Past	Date / Note	Significant	Medical Condition	Current	Never	Past	Date / Note
☐	Dizziness		☐	☐		☐	Mitral valve prolapse		☐	☐	
☐	Emphysema		☐	☐		☐	Mood disorder		☐	☐	
☐	Epilepsy		☐	☐		☐	Multiple sclerosis		☐	☐	
☐	Excessive Daytime Sleepiness		☐	☐		☐	Muscular dystrophy		☐	☐	
☐	Fibromyalgia		☐	☐		☐	Nasal allergies		☐	☐	
☐	Glaucoma		☐	☐		☐	Neuralgia		☐	☐	
☐	Gout		☐	☐		☐	Osteoarthritis		☐	☐	
☐	Heart attack		☐	☐		☐	Osteoporosis		☐	☐	
☐	Heart murmur		☐	☐		☐	Parkinson's disease		☐	☐	
☐	Heart pacemaker		☐	☐		☐	Prior orthodontic treatment		☐	☐	
☐	Heart valve replacement		☐	☐		☐	Radiation treatment		☐	☐	
☐	Hemophilia		☐	☐		☐	Rheumatic fever		☐	☐	
☐	Hepatitis		☐	☐		☐	Rheumatoid arthritis		☐	☐	
☐	Hypertension		☐	☐		☐	Sinus problems		☐	☐	
☐	Hypoglycemia		☐	☐		☐	Sleep apnea		☐	☐	
☐	Immune system disorder		☐	☐		☐	Stroke		☐	☐	
☐	Insomnia		☐	☐		☐	Tendency for ear infections		☐	☐	
☐	Ischemic heart disease (reduced blood supply)		☐	☐		☐	Thyroid disorder		☐	☐	
☐	Kidney problems		☐	☐		☐	Tuberculosis		☐	☐	
☐	Liver disease		☐	☐		☐	Tumors		☐	☐	
☐	Meniere's disease		☐	☐		☐	Urinary disorders		☐	☐	

Other

Medical Condition	Current	Past	Date / Note	Medical Condition	Current	Past	Date / Note
☐		☐	☐		☐	☐	☐	

Medical History

If you have any heart problems, what kind(s)?

☐ Yes ☐ No Have you been told you have a heart murmur?

☐ Yes ☐ No Do you have a current medical problem?

Patient Signature: Date:

Medical History

Blood pressure
- ☐ high and controlled
- ☐ high and not controlled
- ☐ low and controlled
- ☐ low and uncontrolled
- ☐ _____

If you have had rheumatic fever, when? _____

☐ Yes ☐ No Do you have any pain in your chest or shortness of breath?

☐ Yes ☐ No Do your ankles swell?

☐ Yes ☐ No Has your physician ever told you that you are anemic?

If you have had a stroke, when? _____

If you have headaches, how often and where? _____

If you take Aspirin, Advil, Tylenol or another pain reliever, how often? _____

If you have been advised not to take any medications, which? _____

If you have asthma or hay fever, how is it controlled? _____

If you have had tuberculosis, when? _____

Have you ever had glaucoma, when? _____

If you have ever had hepatitis, when? _____

If you have arthritis, how is it controlled? _____

If you ever had a severe blow to the head, when? _____

If your hands and/or feet are sometimes cold, how often? _____

If your diet is medically supervised, for what purpose? _____

☐ Yes ☐ No Do you have difficulty swallowing?

☐ Yes ☐ No Do you have a feeling of something stuck in your throat?

If you ever have any facial pain or pressure, where? _____

☐ Yes ☐ No Do you ever have any pain or pressure behind your eyes?

If you are aware of stiff neck muscles, how often? _____

If you have ever been in traction for a neck injury, when? _____

☐ Yes ☐ No Have you ever had or been advised to have neck surgery?

If you have back pain, where? _____

☐ Yes ☐ No Do your ears feel itchy, stuffy, or congested?

☐ Yes ☐ No Do you have difficulty with pain in your ears when changing altitude?

If your ears ring, buzz, or hiss, how often? _____

Patient Signature: _____ Date: _____

Medical History

☐ Yes ☐ No Have you noticed any changes in your hearing?

☐ Yes ☐ No Are you depressed?

☐ Yes ☐ No Do you have emotional or anxiety/nervousness problems?

If you have gained weight within the last year, how much?

If you have lost weight within the last year, how much?

If you have had any other serious illness, hospitalization or accidents, please explain:

DENTAL HISTORY

When was your last dental visit?

☐ Yes ☐ No Have you been told that you have periodontal (gum) disease?

If you have any existing problems with your teeth, describe:

If you have any dental treatment planned, describe:

☐ Yes ☐ No Do you bite your nails?

☐ Yes ☐ No Have you ever had any oral surgery?

If you have lost any teeth, from what cause?

If so, when have the teeth been replaced?

If you have had orthodontic treatment, when?

If you have ever had extensive dental treatment, when?

If any part of your mouth is sensitive to temperature, pressure, food or drink, where?

☐ Yes ☐ No Do you wear dentures or partial dentures?

☐ Yes ☐ No If so, are they comfortable?

TMJ HISTORY

☐ Yes ☐ No Do you ever have a burning or painful sensation in your mouth?

☐ Yes ☐ No Do you get popping, clicking, or grinding noises when you open or close?

☐ Yes ☐ No Do you ever awaken with an awareness of your teeth or jaws?

If you are aware of clenching during the daytime, how often?

☐ Yes ☐ No Have you ever been told you grind your teeth during sleep?

☐ Yes ☐ No Do you have trouble opening your mouth widely?

If your jaw ever locks open or closed, how often?

☐ Yes ☐ No Do you feel your bite is different, unstable or uncomfortable?

What professional advice or treatment have you had regarding your TMJ, headaches or pain conditions/problems?

Patient Signature: Date:

Medical History

TMJ HISTORY

☐ Yes
☐ No
If you have sought treatment for a TMJ problem, did it help?

Do you or have you had any pain in the following areas?

☐ Jaw
☐ Ear
☐ Face
Other

☐ Neck
☐ Teeth
☐ Head

☐ Yes ☐ No Do your jaw problems affect your ability to chew?

If your diet has changed due to your jaw problems, describe:

☐ Yes ☐ No Do your joint noises affect others while eating?

Dental History

Current dental problems (if any)

Date of last complete dental examination

☐ Sensitive teeth
☐ Gums bleed or hurt
☐ Loose teeth
☐ Noticed a change in bite
☐ Mouth odors or bad tastes
☐ Food becomes caught between your teeth
☐ Clench or grind your teeth
☐ Had past Orthodontic treatment
☐ Have seen a Periodontist
Other

☐ Your bite has been adjusted in the past
☐ Jaw clicks or pops
☐ Difficulty opening or closing mouth
☐ Have been told you have a TMJ problem
☐ Frequent headaches
☐ Want to keep your teeth all your life

If you feel nervous about having dental treatment, what is your biggest concern?

If you have ever had an upsetting dental experience, describe it briefly

If you are not happy with the appearance of your teeth, what would you like to change?

Confidential Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note	Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	Recreational drugs	☐	☐						
☐	HIV/AIDS	☐	☐						

Patient Signature:

Date:

Surgical Operations

- ☐ Appendectomy
- ☐ Back
- ☐ Ear
- ☐ Gallbladder
- ☐ Heart
- ☐ Hernia repair
- ☐ Lung
- ☐ Nasal
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Uvulectomy
- ☐ Periodontal

Other

Family History

Has any member of your family (parent, sibling, or grandparent) had:

- ☐ Cancer
- ☐ Heart disease
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Stroke
- ☐ Sleep disorder
- ☐ Obesity
- ☐ Thyroid disorder
- ☐ Father snores
- ☐ Mother snores
- ☐ Father has sleep apnea
- ☐ Mother has sleep apnea

Social History

Patient's Occupation Employer

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker ☐ Quit

# of packs per day When did you quit?

# of years

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week:

Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda # of cups per day:

Additional:

☐ Regular exercise

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: Date:

I certify that the medical history information is complete and accurate.

Patient Signature: Date:

Diplomat
American Board of
Oral Implantology/
Implant Dentistry

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Financial Policy Acknowledgement Form

Thank you for choosing Dr. Hudson, as your dental provider, we value your patronage. Please note that it is required that you read and sign the financial policy prior to treatment.

In order to comply with Federal and State regulations, our financial policies are as follows: If you will be using dental insurance, we are required to verify dental insurance coverage and proper identity prior to each visit. We appreciate your patience and understanding during this process. Having current and accurate information allows us to process your claim promptly and correctly.

Your insurance will be billed for services rendered. While the filing of a dental claim is a courtesy that we extend to our patients, **WE MUST EMPHASIZE** that our relationship is with you, **NOT** the insurance company. If we do not receive payment from your insurance company within 45 (forty five) days, payment becomes your responsibility.

Please be aware that some and perhaps all of the services provided may be non-covered services by your insurance plan. In such an event, you may ultimately be responsible for payment of these services. If you should have any billing questions, please contact the Billing Department.

Patient Responsibilities

- All co-pays and deductibles must be paid at the time of service. Any remaining balances after insurance has paid must be paid upon receipt of first statement, or a service fee of $25 will be added for each additional statement sent.
- Any balance outstanding past 90 days will be sent to our Collection Agency. **Please ensure that we receive any change of address.**
- A charge of $45 will be assessed for each returned check to cover corresponding bank fees.
- A charge of $50 will be assessed for any appointment missed or not cancelled 24 hours prior to appointment time.

I have read this acknowledgement form and agree to abide by the terms

Patient/Guardian Signature_____ **Date**_____