PATIENT REGISTRATION

Patient Name _____ Main contact number _____ (home / cell)

Address _____ City _____ State _____ Zip _____

Email Address _____ Alternate contact number _____ (home / cell)

Occupation _____ Employer _____

Business Address _____ Business Phone Number _____ Ext. _____

Social Security Number _____ Date of Birth _____ Circle: Male / Female

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (Skip if same as above)

Name _____ Phone Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____

Business Address _____ Business Phone Number _____ Ext. _____

Social Security Number _____ Relationship to Patient _____

YOUR SPOUSE

Name _____ Business Phone Number _____

Occupation _____ Employer _____ Social Security Number _____

Business Address _____ City _____ State _____ Zip _____

DENTAL INSURANCE

Primary Carrier

Employee _____ Employer _____

Insurance Company _____ Group Number _____

Social Security Number _____ Date of Birth _____

Secondary Carrier

Employee _____ Employer _____

Insurance Company _____ Group Number _____

Social Security Number _____ Date of Birth _____

GETTING TO KNOW YOU

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

Is another member of your family or relative a patient at our office?

Name _____ Relationship _____

Person to contact for emergency

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Closest relative not living with you

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

CONSENT FOR TREATMENT/FINANCIAL RESPONSIBILITY: This is to certify that I, Undersigned: (1) Consent to the performing of the Dental Procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated: (2) Consent to releasing information to my insurance company: (3) Agree to pay the fees associated with the dental procedures, including the award of thirty percent collection agency fee, all reasonable attorney's fees, at trial and on appeal, as determined by the court for the legal efforts necessary to obtain the fees.

Signature of Patient (or guardian if minor) _____ Date _____

Health History Form

Patient Name:_____ **Today's Date:**_____

If you are completing this form for another person, what is your relationship to that person?

Relationship: _____ Your Name: _____

Dental Information **For the following questions, please mark (x) your responses to the following questions.**

	Yes	No	DK (*don't know*)
Do your gums bleed when you brush or floss?			
Are your teeth sensitive to cold, hot, sweets or pressure?			
Does food or floss catch between your teeth?			
Is your mouth dry?			
Have you had any periodontal (gum) treatments?			
Have you had orthodontic (braces) treatment?			
Have you had any problems associated with previous dental treatment?			
Is your home water supply fluoridated?			
Are you currently in dental pain or discomfort?			

	Yes	No	DK
Do you have any clicking, popping, or discomfort in the jaw?			
Do you grind or clench your teeth?			
Do you get sores or ulcers in your mouth?			
Do you wear dentures or partial dentures?			
Have you had a serious injury to your head or mouth?			

When was your last dental visit? _____

What services were provided at that visit? _____

Date of last x-rays:_____

What is the reason for your visit today? _____

Medical Information

	Yes	No	DK
Are you now under the care of a physician?			
Are you in good health?			
Are you currently taking any prescription or over the counter medicines?			

Physician Name:_____

Physician Phone: ( ) _____ - _____

Physician Address/City/State/Zip:

_____

Date of last physical exam: _____

	Yes	No	DK
Have you had a serious illness, operation, or been hospitalized in the past 5 years?			
Are you currently being treated for any conditions?			

If yes, what was the illness or problem?

_____

_____

If yes, what conditions are being treated?_____

_____

Please list all medicines, vitamins, natural or herbal preparations and/or supplements ON THE BACK of this form.

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's diease, multiple myeloma or metastatic cancer?	Yes	No	DK

Are you taking or scheduled to begin taking either of the Medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's Disease?	Yes	No	DK

	Yes	No	DK
Do you use tobacco (smoking,snuff, chew)?			

If so, how interested are you in stopping?

(Circle One) VERY / SOMEWHAT / NOT INTERESTED

	Yes	No	DK
Do you use recreational drugs?			
Do you drink alcoholic beverages?			

If yes, how much do you typically drink in a week?

_____

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?	Yes	No	DK

Date: _____ Surgeon:_____ Have you had any complications?_____

Women Only:	Yes	No	DK
Are you pregnant?			
Taking birth control pills or hormonal replacement?			
Are you nursing?			

Number of Weeks: _____

Allergies: Are you allergic to or had a reaction to: (To all YES responses, specify type of reaction.)

Local anesthetics_____

Penicillin or other antibiotics_____

Codeine or other narcotics_____

Latex_____

Other Allergies:_____

Metals_____

Sulfa Drugs_____

Barbiturates, sedatives, or sleeping pills_____

Food/Milk_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	Yes	No	DK

Name of physician or dentist making recommendation: _____

Phone: ( ) _____ - _____

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems:

	Yes	No	DK
Cardiovascular disease			
Angina			
Arteriosclerosis			
Congestive heart failure			
Congenital heart disease			
Coronary artery disease			
Damaged or replaced heart valves			
Heart attack			
Low blood pressure			
High blood pressure			
Abnormal bleeding			
Anemia			
Blood transfusion			
If Yes, Date: _____			
Hemophilia			
AIDS or HIV infection			
Arthritis			
Autoimmune disease			
Rheumatoid disease			
Systemic lupus (erythematosus)			
Asthma			
Emphysema			
Sinus trouble			
Cancer/Chemotherapy/Radiation Treatment			
Chest pain upon exertion			

	Yes	No	DK
Chronic Pain			
Diabetes Type I or II			
Eating Disorder			
Gastrointestinal disease			
G.E. Reflux/persistent heartburn			
Ulcers			
Thyroid problems			
Stroke			
Glaucoma			
Hepatitis, jaundice or liver disease			
Epilepsy			
Fainting spells or seizures			
Neurological disorders			
If Yes, Specify: _____			
Sleep Disorder			
Mental health disorders			
Specify: _____			
Recurrent infections			
Type infections: _____			
Kidney problems			
Night sweats			
Osteoporosis			
Persistent swollen glands in neck			
Severe headaches/migraines			
Severe or rapid weight loss			
Sexually transmitted disease			
Excessive urination			

Do you have any disease, condition, or problem not listed above that you think we should be aware of?
If so, Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient/Legal Guardian Date

For Completion By Dentist

Comments: _____

_____
Dentist Signature/Date

Blood Pressure	**Date**

Health History Updates

Any Changes?	Yes/No	Date: _____	Patient Initials: _____
Any Changes?	Yes/No	Date: _____	Patient Initials: _____
Any Changes?	Yes/No	Date: _____	Patient Initials: _____
Any Changes?	Yes/No	Date: _____	Patient Initials: _____
Any Changes?	Yes/No	Date: _____	Patient Initials: _____
Any Changes?	Yes/No	Date: _____	Patient Initials: _____

Medical Information

Please list all medications, including vitamins, natural or herbal preparations and/or diet supplements below:

Date	Medication	Condition

For Office Use Only: Changes to Patient Health History

Date	Changes	Intials

WEST 10TH DENTAL GROUP

OUR MISSION

Our work is dedicated to providing exceptional dental care for patients of all ages. We strive to provide comprehensive care, educate each patient to the best of our ability, and provide a pathway to healthy smiles for life.

Name _____

Initial_____ APPOINTMENTS

Should you need to change your appointment date or time, we require a 48 hour notice to avoid a charge. This ensures we are able to offer the most convenient times to you and our other patients.

Initial_____ INSURANCE POLICIES

To assist our patients, we will file insurance claims for each visit. We accept most insurance plans and we are network providers for: Aetna PPO, Assurant, Cigna PPO, Connection Dental, Delta Dental PPO, Delta Dental Premier, Dental Blue 300, Dental Wellness Partners, Health Resources, Maverest, Metlife, United Healthcare, and Hoosier Healthwise for our Pediatric patients.

Initial_____ PAYMENT ARRANGEMENTS

Financial obstacles should not stand in the way of your healthy smile! Our office accepts cash, check, and all major credit cards. Zero interest and low interest payment plans are available through our financial partners Care Credit and Citi Health. Applications can be processed by our office or in the privacy of your own home. Any financial arrangements needed must be established prior to the time of service. Please contact us with any questions and we will be happy to assist you.

ACKNOWLEDGEMENT AUTHORIZATION/RELEASE
RECEIPT OF PRIVACY PRACTICES

□ I, _____, have received a copy of West 10th Dental Group's Notice of Privacy Practices.

_____ Date_____
(Signature)

□ I hereby authorize and request West 10th Dental Group, and/or a representative of West 10th Dental Group, to:

- Discuss my dental treatment with
- Disclose and give copies to
- Discuss my financial account with
- Disclose and give copies of financial account to

Name_____

Relationship_____ Phone #_____

Name_____

Relationship_____ Phone #_____

This will include any and all records and information concerning the undersigned which you may have in your possession, including but not limited to the following: dental records, including operative records, diagnosis, dental history, findings and procedures, treatment and interviews, radiographs, diagnostic models and additional materials.

In consideration of such disclosure on the part of the above name person or institutions, I hereby release them from any and all liability arising from such disclosure.

_____ Date_____
(Signature)

□ I hereby authorize West 10th Dental Group and/or a representative of West 10th Dental Group to contact me by the following:

- Mail
- E-mail Address_____
- Text Message
- Cell Phone
- Telephone
- Voicemail
- Answering Machine

_____ Date_____
(Signature)