PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Social Security Number: _____ Email: _____

Sex: ☐ Male ☐ Female

Referred By: ☐ Family/Friend: _____ ☐ Google ☐ Facebook

☐ Insurance Company ☐ Other: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

_____

_____

RESPONSIBLE PARTY: Patient is: ☐ Responsible Party

First Name: _____ Last Name: _____ Middle Initial: _____

Relation to patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Social Security Number: _____ Email: _____

PRIMARY INSURANCE INFORMATION:

Dental Insurance Company: _____

ID Number/Member ID: _____

Policy Holder Name: _____

Policy Holder Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Address: _____

Policy Holder's Zip Code: _____

SECONDARY INSURANCE INFORMATION:

Dental Insurance Company: _____

ID Number/Member ID: _____

Policy Holder Name: _____

Policy Holder Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Address: _____

Policy Holder's Zip Code: _____

In Office Signatures:

I have read and understand the Notice of Privacy Practices and Authorization (HIPPA) and the office financial policy.

Signature: _____ Date: _____

Relationship to patient: _____

I give my consent to Bloomfield Dental to notify/contact me via unencrypted email or text which may include personal health information and billing information. (ex: appointment reminders, notifications)

Signature: _____ Date: _____

Relationship to patient: _____

MEDICAL HISTORY

Patient Name: _____ Birthdate: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

If you answer yes to the following questions, please explain	YES	NO
Are you under a physician's care now?	☐	☐
Have you ever been hospitalized or had a major operation?	☐	☐
Are you taking any medications, pills, or drugs?	☐	☐
If yes, please provide a MED LIST:	☐	☐
Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates?	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐

*Women, are you: (circle all that apply) Pregnant Trying to get pregnant Taking oral contraceptives Nursing

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal

☐ Latex ☐ Sulfa Drugs ☐ Other If yes, please explain: _____

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

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Cold Sores/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Osteoporosis	☐	☐
Alzheimer's Disease	☐	☐	Congenital Heart Defects	☐	☐	Heart Pacemaker	☐	☐	Pain in Jaw Joints	☐	☐
Anaphylaxis	☐	☐	Cortisone Medicine	☐	☐	Heart Trouble/Disease	☐	☐	Psychiatric Care	☐	☐
Arthritis/Gout	☐	☐	Diabetes	☐	☐	Hemophilia	☐	☐	Radiation Treatments	☐	☐
Artificial Heart Valve	☐	☐	Drug Addiction	☐	☐	Hepatitis A, B, C_____	☐	☐	Rheumatic Fever	☐	☐
Artificial Joint	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Asthma	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	Excessive Bleeding	☐	☐	Irregular Heartbeat	☐	☐	Stomach/Intestinal Disease	☐	☐
Bruise Easily	☐	☐	Fainting Spells/Dizziness	☐	☐	Kidney Problems	☐	☐	Stroke	☐	☐
Cancer Type:_____	☐	☐	Frequest Cough	☐	☐	Liver Disease	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Frequent Headaches	☐	☐	Lung Disease	☐	☐	Tonsillitis	☐	☐
Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Mitral Valve Prolapse	☐	☐			

Have you every had any serious illness not listed above? _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent, or Guardian _____ Date: _____

DENTAL HISTORY

Name: _____ Birthdate: _____

How would you rate the condition of your mouth? Excellent Good Fair Poor

How long has it been since you have seen a dentist? _____

What is your immediate concern? _____

How many times a day do you brush? _____ Floss? _____

Do you use a rotary or electric toothbrush? _____

Do you wear an appliance (splint) at night? _____

Smile Characteristics

	YES	NO
1. Is there anything about the appearance of your teeth you would like to change? _____	☐	☐
2. Would you like your teeth to be whiter or brighter? _____	☐	☐

Please answer yes or no to the following:

	YES	NO
Fearful of dental treatment	☐	☐
Difficulty getting numb	☐	☐
History of braces	☐	☐
Jaw (TMJ) problems	☐	☐
Trauma to face/teeth	☐	☐
Chewing ice	☐	☐
Fingernail biting	☐	☐
Food collecting in between teeth	☐	☐

	YES	NO
Pain when brushing	☐	☐
Bleeding gums	☐	☐
Dry Mouth	☐	☐
History of gum disease	☐	☐
Sensitivity to hold/cold and/or sweets	☐	☐
Pain/sensitivity when bitting	☐	☐
Bad breath	☐	☐
Sores or growths in your mouth	☐	☐

Bloomfield DENTAL
let your smile bloom.