PATIENT REGISTRATION

Date:

Patient Information:

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

Patient is: □ Responsible Party □ Policy Holder Preferred name:_____

Address: _____ City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Sex: o Female o Male Marital Status: o Married o Single o Divorced o Separated o Widowed

Birth date:_____ Social Security #:_____ Drivers Lic# _____

E-mail: _____ □ I would like to receive text/email correspondences

Referred By: _____

Employment Status: o Full Time o Part Time o Self Employed o Retired o Unemployed

Employer Name/City, State:_____

Student Status: oFull Time o Part Time School or University/College _____

Responsible Party: (if someone other than the patient)

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

Address: _____ Address 2:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

o Responsible Party is Policy Holder for Patient o Primary Policy Holder o Secondary Policy Holder

Emergency Contact Information:

Name: _____ Relationship:_____ Contact #_____

Primary Insurance Information:

Name of Insured:_____ Relationship to Insured: oSelf oSpouse oChild o Other

Insured Social Security or ID#:_____ Insured Birthdate:_____

Employer:_____ Insurance Company:_____

Secondary Insurance Information:

Name of Insured:_____ Relationship to Insured: oSelf oSpouse oChild o Other

Insured Social Security or ID #:_____ Insured Birth date: _____

Employer:_____ Insurance Company: _____

Time 10:36 AM

Midtowne Smiles, PC

Date 4/11/2019

Patient Medical History

Patient Name:

Birth Date:

Date Created:

DISCLAIMER

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.

Are you under a physician's care now? If yes, please list condition(s), physician name(s), and phone number(s)	◯ Yes ◯ No	If yes
Have you ever been hospitalized,had a major operation, or had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs? If yes please list.	◯ Yes ◯ No	If yes
Are you or have you ever taken Fosamax, Boniva, Actonel or any other medicaton containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco (smoking, snuff, chew, bidis)?	◯ Yes ◯ No	If yes
Do you use controlled substances (drugs)?	◯ Yes ◯ No	If yes

WOMEN: Are you...

☐ Pregnant/Trying to get pregnant: ☐ Nursing: ☐ Taking oral contraceptives?

ALLERGIES: Are you allergic, or have you had a reaction, to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other allergies - Please give description ☐ If yes

HEART HISTORY: Do you have, or have you had, any of the following:

☐ Heart Murmur ☐ Mitral valve prolapse ☐ Artificial heart valves ☐ Rheumatic fever

☐ Heart Pacemaker ☐ Congenital HeartDisorder ☐ Heart Attack/Failure ☐ Heart Trouble/Disease

☐ Irregular heartbeat

Other Heart Problem not listed - Please give description ☐ If yes

Do you require premedication prior to dental treatment? If yes, please list which antibiotic you take. ◯ Yes ◯ No If yes

JOINT REPLACEMENT: Have you had an orthodpedic replacment of the following:

Hip / date of replacement ☐ If yes

Knee / date of replacement ☐ If yes

Other / date of replacement /description ☐ If yes

Do you require premedication prior to dental treatment? If yes, please list which antibiotic you take. ◯ Yes ◯ No If yes

MEDICAL HISTORY: Do you have, or have you had, any of the following:

AIDS/HIV Positive	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Diabetes Type 1 / Type 2	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Sleep Apnea	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Breathing problems	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No

Have you ever had any serious illness not listed above? If yes, please give description. ◯ Yes ◯ No If yes

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Date: _____

Patient Name: _____

Please check any of the following that applies to you:

- o Sensitivity (hot, cold, sweets, etc.)
- o Tooth pain or discomfort when chewing
- o Headaches, earaches, neck pain
- o Jaw joint pain
- o Teeth or fillings breaking
- o Grinding or clenching teeth
- o Bleeding, swollen or irritated gums
- o Loose, tipped or shifting teeth
- o Bad breath or bad taste in your mouth

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

- o Bite Splint / Night guard
- o Dentures / Partials
- o Orthodontics / Braces
- o Periodontal (gum) treatments
- o Teeth Extractions
- o Implants
- o Crowns / Bridges

Previous Dentist: _____

City/State: _____

Please share the following dates:

- Last dental cleaning _____
- Last oral cancer screening _____
- Last complete x-rays _____

Our office offers many treatments to enhance patient smiles. Please check if you would like to discuss, or obtain more information on any of the following:

- o Whitening procedures
- o Invisible aligners
- o Close spaces
- o Replace black metal fillings with natural, tooth colored fillings
- o Repair chipped teeth
- o Replace missing teeth
- o Replace old crowns that don't match
- o Veneers / Smile makeovers

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

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you regarding your dental health?

_____

_____

_____

_____

_____

Midtowne Smiles
Cosmetic & Family Dentistry
Daniel Burton DDS

CARE AND PAYMENT

The office of Midtowne Smiles, PC is proud to be part of a team whose primary goal is to provide the finest and most comprehensive dental care available today. To assist you with your dental care investment, we provide the following payment options.

- **Cash, includes personal checks and money orders**
- **Visa, MasterCard, Discover, American Express**
- **FlexPlans and Health Savings Account**
- **CareCredit, or LendingClub patient financing offering:**
  - Flexible financing options. (with approved credit)
    No interest payment plans – from 3 to 12 months 0%
    Low interest payment plans – from 18 to 60 months
  - Credit decision only takes a few minutes.
  - No annual fees or prepayment penalties.

The best dental health services are based on a friendly, mutual understanding between provider and patient.

We invite you to discuss with us any questions regarding our services.

- **Payment is required** for all services rendered at the time of patient visit*.
- **As your dental care is our top priority,** if you have dental insurance our office will be happy to assist you with the submission of your claim(s) Our office does not accept insurance as payment in full. We will help you maximize your dental benefits, however, your policy/contract is with you, and your insurance company
- **I authorize the staff** to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Signature of Patient/Responsible Party **Date**

*If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.