Date _______________

Patient Registration

Thomas Schierbrock, DDS   Andrea Cardenzana, DDS   Caitlin Beresford, DDS

PATIENT INFORMATION

Name ____ Single___ Married___ Widow___ Divorced___
Last   First   Init

Soc. Sec. # ____________________   Birth date__________________   Sex: M____ F____

Home phone_____________________   Cell Phone __________________   Business Phone ___________________

Address_____________________________________ City___________________________ State______ Zip___________

Employers name and address ____ Current position_________________

Spouse __________________________________ Cell Phone ________________   Business phone _______________

Spouse employer's name and address _______________________________________Spouse's occupation______________

Names of dependents_____________________________ Whom may we thank for referring you? _____________________

In case of emergency who should be notified? ____ Phone________________

Any other phone numbers we may need ____

Primary EMAIL address ____

How do you prefer to be contacted for future appointments? EMAIL / POSTCARD / PHONE CALL

PRIMARY DENTAL INSURANCE (NEED ALL INFORMATION ON POLICY HOLDER)

Person responsible for account ________________________Relationship to Patient____________ Phone_______________

Employer_________________________ Bus. Address & phone____

Insurance Company ____ ID #____________________________

Group #______________ Subscriber #________________ Soc. Sec. #_____________ Birth date _______

ADDITIONAL DENTAL INSURANCE (if patient is covered by additional insurance)

Subscriber name ____________________________ Relationship to Patient________________ Phone _________________

Employer______________________________ Insurance Company_____________________ ID #_____________________

Group #______________ Subscriber #________________ Soc. Sec. # ____________ Birth date ________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above company (s) and assign directly to Dr. Schierbrock/Dr. Cardenzana/Dr. Beresford all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

HIPAA: I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

____   _________________________   _____________
Responsible Party Signature   Relationship   Date

Dental History (confidential)

Reason for today's visit? ____________________________ Any discomfort at this time? __________________________

Previous dentist/location_______________________________ How often do you see a dentist? ________________

Date of last dental care and cleaning._____________________ X-rays? ___Yes ___No When? ________________

When do you brush? ___After breakfast ___Before Bed ________ Other times? Do you floss? ________________

Do you have sensitivity to:

Hot Cold Pressure Sweets Biting Eating/Chewing

Do you have/use:

Battery toothbrush Proxy Brush Toothpicks Water Jet Xylitol Gum Mouth Rinse Bleaching

Sensitivity toothpaste Prescription Fluoride Sports Mouth guard Night guard Mouth piercings

Maxillary Partial Mandibular Partial Maxillary Denture Mandibular Denture Retainers

Have you lost any teeth? YES / NO Why?________________ Complications with extractions? YES / NO ____________

Do you have bleeding gums? YES / NO FREQUENTLY / OCCASIONALLY / RARELY

Have you had gum treatments? YES / NO When/where/why? ____

Have you had your teeth straightened? YES / NO When/Where ____

Do you grind or clench their teeth? YES /NO When? _____________ Has this habit changed recently? YES / NO _________

Do you have popping or clicking noises when you chew? YES / NO Does it cause discomfort? YES / NO _____________

Have you had treatment for TMJ problems? YES / NO Where/When? ______________________________________

Are you aware of any sores, swellings or lumps in your mouth? YES / NO __________________________________

Do you have frequent sinus infections? YES / NO Do you have any other sinus problems? YES / NO

How much soda pop/sports drinks/bottled drinks/flavored water/energy drinks do you drink a day and what kind? _________

____ Has this habit changed recently? __________________________

Do you have any fear of having dentistry done? YES / NO Why? ____

How do you feel about your teeth? ____

Is it ok to have one of the other dentists in the practice for an exam if the usual dentist is not available? YES / NO

Patient's Name_____________________________ date_________

Medical History (confidential)

Medical Doctor's name and location?____phone________________

Date last seen by physician? ______________ Do you have any special needs____________________________________

Have you ever been hospitalized or had a major operation? ____

____

Have you ever had a serious head or neck injury? YES / NO If so, when? ____

Do you have an artificial joint? Yes / No Type? _______ When? ________ Orthopedic surgeon _____________________

Are you taking medication for osteoporosis? Yes / No Name of medication _________________________________

Are you diabetic? Yes / No Blood sugar level____

If you are in a wheelchair, can you transfer to the dental chair? Yes / No Do you need help to transfer? Yes / No

Women: ___Pregnant/trying to get pregnant ___Nursing ___ Birth control medication ___ Hormone Replacement Therapy

Do you currently have or have had in the past any of the following?

___Acid Reflux
___ADHD
___AIDS/HIV positive
___Alzheimer's disease
___Anaphylaxis
___Anemia
___Angina
___Anxiety
___Arthritis/Gout
___Artificial Heart Valve*
___Asthma
___Autism
___Back problems
___Bipolar Disorder
___Blood disease
___Blood Transfusion
___Breathing problems
___Cancer*
___High Cholesterol
___Chemotherapy*
___Chemical Dependency
___Chest pains
___Circulatory problems
___Cold sores
___Congenital Heart Disorder*
___Convulsions
___COPD
___Cortisone Medications
___Coughing up blood
___Dementia
___Depression
___Diabetes
___Dialysis*
___Drug/Alcohol addiction
___Eating Disorder
___Emphysema
___Epilepsy or Seizures
___Excessive Bleeding/Bruising
___Excessive thirst
___Fainting spells/Dizziness
___Frequent cough
___Frequent headaches
___Glaucoma
___Hay Fever
___Hearing problems
___Heart Attacks/Failure
___Heart Murmur
___Heart Pace Maker
___Heart Stent*
___Heart Trouble/Disease
___Hemophilia
___Hepatitis A
___Hepatitis B or C
___Herpes
___High Blood Pressure
___Hives or Rash
___HPV
___Hypoglycemia
___Irregular Heartbeat
___Jaundice
___Joint Replacement*
___Kidney problems
___Leukemia
___Liver Disease
___Low Blood Pressure
___Lung Disease
___Mitral Valve Prolapse
___Nervous problems
___Osteoporosis*
___ Psychiatric Care
___Parathyroid Disease
___ Pain in the jaw or joints
___Radiation Treatment*
___Recent Weight Loss
___Respiratory Disease
___Rheumatic Fever
___Rheumatism
___Scarlet Fever
___Shingles
___Shortness of breath
___Sickle Cell Disease
___Spina Bifida
___Shunt/Fusiport*
___Stomach/Intestinal Disease
___Stroke/ TIA
___Swelling of Limbs
___Taken Phen-Fen or Redux
___Thyroid disease
___Tonsillitis
___Tuberculosis
___Tumors or Growths
___Ulcers
___Vision problems
___Wheelchair

Have you had any serious illnesses not listed above?____

____

Have you ever been told that you need to take antibiotics before visiting a dentist? ___________________________________

PRE-MED Yes / No Why?______________________ Pharmacy preferred__________________________

Medications

Prescription medications, pills, or drugs (Name, used for and dosage)

________________________ ________________________ ________________________ ________________________

________________________ ________________________ ________________________ ________________________

________________________ ________________________ ________________________ ________________________

________________________ ________________________ ________________________ ________________________

Over the counter medications, pills, or drugs

Aspirin Ibuprofen Tylenol Aleve (Naproxen)

Multi Vitamin Sinus Medication ________________ __________________

Do you regularly take dietary supplements or herbal medicines? ____Yes ____No

If YES do you regularly take any of the following?

Diet or Energy supplements	Echinacea	Garlic	Ginger	Ginko	Ginseng
Horse Chestnut	St. John's Wort	Valerian	Vitamin E	Kava	Fish Oil >3g/day

Do you regularly use any other natural or herbal health products? ____Yes ____No

Herbal/natural medications, pills, or treatments

________________________ ________________________ ________________________ ________________________

Have you had any side effects from herbs? ___Yes ___No Have you recently stopped taking any herbs? ___Yes ___No

Have you substituted herbs for prescription or over-the-counter drugs? ___Yes ___No

Do you use tobacco? Yes / No Cigarettes / Cigars / Pipe / Smokeless Are you interested in quitting? Yes / No

Have you used or are using recreational drugs (confidential)? Yes / No ____________________________________

Allergies (please check any allergies you might have)

____Aspirin ____Penicillin ____Codeine ____Sulfa ____Acrylic ____Metal ____Latex

____Local Anesthetics ____Food ____Environmental (dust, mold, pets)

Any other allergies____

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 health. It is my responsibility to inform the dental office on any changes in my medical status. I authorize the dental staff to perform any necessary dental treatment.

____

Signature of patient or responsible party Date

Updates:

Date ______Init ____ Date________ Init ____ Date________ Init ____ Date________ Init ____ Date________ Init ____

Date_____ Init ____ Date________ Init ____ Date________ Init ____ Date________ Init ____ Date________ Init ____