Date _____

Patient Registration

Caitlin Beresford, DDS Andrea Cardenzana, DDS Chad Menke, 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 / TEXT / 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. Menke/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? _____

Patient's Name_____

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

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
___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?_____

_____

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 herbals? ___Yes ___No Have you recently stopped taking any herbals? ___Yes ___No

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

Do you use tobacco? Yes / No Cigarettes /Cigars /Pipe /Smokeless /e-Cig **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_____

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

PRE-MED Yes / No Why?_____ Pharmacy preferred_____

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 ____