

PATIENT REGISTRATION

Patient Name _____ MI _____ Preferred Name _____ Birth Date _____
Address _____ City/State _____ Zip _____
Home # _____ Work # _____ S.S. # _____ Married ___ Divorced ___ Single ___
E-mail Address _____ Cell # _____
Physician _____ City/State _____ Zip _____
Emergency Contact _____ Phone # _____
Whom May We Thank For This Referral _____

Person Financially Responsible for Account

Name _____ Relationship to Patient _____ Home # _____
Address (if different) _____ Work # _____
Employer _____ Occupation _____
If minor, Parent Daytime Phone # _____

Dental Insurance YES NO

Primary Insurance

Employer _____
Employee _____
Date of Birth _____ Group # _____
Social Security _____
Insurance Co. Name _____
Address _____

Secondary Insurance

Employer _____
Employee _____
Date of Birth _____ Group # _____
Social Security _____
Insurance Co. Name _____
Address _____

MEDICAL HISTORY

Last Physical Date _____ Results _____
Have you been under the care of a medical doctor during the past two years?..... YES NO
If yes, for what? _____
Are you taking any medication, drugs or pills now?..... YES NO
If yes, please list name and dosage _____
Are you aware of having an allergic (or adverse) reaction to any medication/substance?..... YES NO
If yes, please list _____
Have you been a patient in the hospital during the past five years? YES NO
If yes, for what? _____

Please circle the following conditions you have or have had:

Use Tobacco	Osteoarthritis	HIV Positive
Heart Attack	Rheumatoid Arthritis	AIDS
Heart Surgery	Ulcers	Cold Sores/Fever Blisters
Congenital Heart Disease	Glaucoma	Blood Transfusion
High Blood Pressure	Tuberculosis	Hemophilia
Heart Murmur	Emphysema	Sickle Cell Disease
Mitral Valve Prolapse	Asthma	Neurological Disorders
Artificial Heart Valve	Seasonal Allergies/Hay Fever	Anxiety/Nervousness
Heart Pacemaker	Latex Sensitivity or Allergy	Psychiatric/Psychological Care
High Cholesterol	Chronic Sinus Congestion	Fainting or Dizzy Spells
Stroke	Cancer	Epilepsy or Seizures
Diet (Special/Restricted)	Radiation Therapy	Hypo/Hyperthyroidism (circle one)
Artificial Joints	Chemotherapy	Taken Fen-Phen or Redux
Require Premedication	Hepatitis A, B or C (circle one)	Taken Bisphosphonate Drugs like Actonel, Boniva, or Fosamax
Rheumatic Fever	Liver Disease	Gastric Bypass or Similiar Surgery
Diabetes I or II (circle one)	Jaundice	
Kidney Problems	Veneral Disease	

Women

Pregnant or thinking of becoming pregnant?
Yes _____ Months No
Nursing? Yes No
Taking Birth Control Pills? Yes No

DENTAL HISTORY

Date of last dental visit _____ Last dental cleaning _____ Last full mouth X-rays _____

Previous Dentist's Name _____ Address _____

City/State _____ Zip _____ Telephone _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use?(Sonicare, Waterpic, Toothpick, etc.) _____

Do you have any dental problems now? Yes No If yes, please describe: _____

(Please circle if yes)

Are any of your teeth sensitive to:

Hot or Cold

Biting or Chewing

Sweets

Have you ever had:

Orthodontic treatment

Oral surgery

Periodontal treatment

Bite adjusted

Bite Plate/ Mouth guard

Injury to mouth or head

Clicking or popping of the jaw

Pain? (Joint, ear side of face)

Difficulty in chewing on either side of the mouth

Headaches, neck aches, shoulder aches or sore muscles

Do you feel you have bad breath?Yes No

Do your gums bleed or hurt?Yes No

Have your parents experienced gum disease?Yes No

Have your parents experienced tooth loss?Yes No

Does food become caught in between your teeth?Yes No

Do you have loose teeth or a change in your bite?Yes No

Are you satisfied with your teeth's appearance?Yes No

Would you like to keep all your teeth all your life?Yes No

Are you nervous about having dental treatment?Yes No

If yes, what is your biggest concern? _____

Ever have an upsetting dental experience?Yes No

If yes, please describe _____

Do you:

Clench or grind your teeth while awake or asleep?Yes No

Chew or hold foreign objects with your teeth?Yes No

(pencils, pipe, pens, nails, fingernails)

Mouth breathe while awake or asleep?Yes No

Have tired jaws, especially in the morning?Yes No

Bite your lips or cheeks regularly?Yes No

Snore or have sleep apnea?Yes No

CONSENT FOR TREATMENT

I have reviewed this questionnaire and answered its questions accurately to the best of my knowledge. I understand that the answers I have provided will be used by Dr. Buchholtz to determine appropriate dental treatment. I agree to notify Dr. Buchholtz if any health changes occur. I authorize Dr. Buchholtz and the dental staff to perform the necessary dental services. I authorize the dental staff to release all information necessary to secure payment of benefits. I authorize my insurance company to pay Dr. Buchholtz directly. I authorize use of this signature on all insurance submissions. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered. I understand that I am financially responsible for any charges not covered by my dental insurance.

Patient _____ Date _____

Parent or Responsible party _____ Relationship to Patient _____