Sandston Comprehensive Dentistry

NEW PATIENT REGISTRATION FORM

PLEASE COMPLETE ALL SECTIONS IN THEIR ENTIRETY

Today's Date: [Date]	**Primary Care Physician: [PCP]**	**PCP Phone #:**
Preferred Pharmacy Name:	**Pharmacy Location:**	**Pharmacy Phone #:**

PATIENT INFORMATION

Last name: **First:**	**Middle:**	**Marital status:** **Married, Single, Divorced, Other**

Preferred Name	**Birth date:**	**Age:**	**Sex: M F**	**Soc. Security #:** **Driver License #:**	**IN CASE OF EMERGENCY** **Emergency Contact Name:** **Phone #:** **Relation:**

Address:

City: **State:** **Zip:** **Email address:**

Home phone no.:	**Cell phone no.:**	**Is above named patient covered by insurance?** **Yes No** **If Yes, See Insurance/Subscriber Info Section below**

Occupation:	**Employer:**	**Employer Phone:**

Referred by:

Other family members seen here:

INSURANCE/ SUBSCRIBER INFORMATION

(Please give your insurance card to the receptionist.)

(dependent minor accounts only) **Name of person responsible for bill:** **Birth date:**	**Address (if different):**	**Home phone #:** **Cell phone #:**	**Guarantor's Soc. Sec#:**	
Employer Name:	**Employer Address:**	**Employer phone#:**		
Subscriber's name:	**Subscriber relationship to Patient:** **Spouse, Father, Mother, Other** **If Other, Please explain:**	**Birth date:**	**Subscriber's Soc Sec. #:**	

DEPENDENT STUDENT INFORMATION

Student Status: **Full-Time Part-Time N/A**	**School Name:**	**School Address:**

DENTAL INFORMATION

Reason for today's visit: Exam and Cleaning Consult Emergency Are you in pain? Yes No If yes, how long?

Last dental exam_____ Last dental x-rays_____ Times per day you brush?_____ Times per week you floss?_____

How would you rate your smile (worst)1 2 3 4 5 6 7 8 9 10 (best)

What would you like to change about your smile?_____

MEDICAL HISTORY

Are you in good health? Yes No Are you under the care of a physician? Yes No Height_____ Weight_____

Have you had any illnesses, operations, or been hospitalized in the past 5 years? Yes No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures? Circle all that apply

Rheumatic fever	Asthma	Bleeding tendency	Low blood sugar
Mitral valve prolapse	Hay fever/ sinus problems	Jaundice/ Liver Disease	Kidney trouble
Heart murmur	Snoring/ sleep apnea	Hepatitis	Are you on dialysis? Y or N
High Blood Pressure	Respiratory problems	HIV/ AIDS	Arthritis/ Joint disease
Low blood Pressure	Tuberculosis	Infectious Mononucleosis	Stomach ulcers
Chest pain/ angina	Emphysema	Gallbladder trouble	Contagious diseases
Heart attack(s)	Do you smoke? Y or N	Fainting spells	Delay in healing
Irregular heart beat	Do you use smokeless tobacco? Y or N	Convulsions/ Epilepsy	Anemia
Cardiac pacemaker	Blood transfusion	Stroke	Tumor or growth
Heart surgery	Blood disorder	Thyroid trouble	Radiation/ Chemotherapy
Damaged heart valves	Bruise Easily	Diabetes	Are you on a diet? Y or N
Bronchitis/chronic cough	History of drug abuse	A history of alcohol abuse	Contact lenses
Chronic fatigue/ night sweats	Eye disease/ Glaucoma	Sexually transmitted diseases	Malignant hyperthermia
Mental health problems	Abnormal bleeding	Swollen ankles	
Are you immunosuppressed? Y or N (possibly from transplant surg.)	Problems w/ immune system? (possibly from med./surg.)	Joint Replacement? Y or N, If so, date of replacement_____ Which joint?_____ Orthopedic Doctor Name_____	

Has premedication with antibiotic prior to dental treatment ever been recommended? Y or N

MEDICATIONS AND ALLERGIES

Are you now taking? Circle all that apply

Nerve pills	Tranquilizers	Bone density medication:	Antidepressants
Stimulants	Muscle relaxers	(ex. Aredia, Zometa, Fosamax, Actonel OR	Insulin
Pain killers	Diet pills (past or present)	Any IV Cancer treatment meds)	
Blood thinners (Coumadin, Aspirin, Advil)			

Please list all medication(s) you are taking (including natural, herbal, or homeopathic products):

_____

_____

_____

Are you allergic to or had a reaction to:

Penicillin Sulfa Amoxicillin Valium or other tranquilizers Codeine or other narcotics Aspirin Sodium pentothal Local anesthetic (numbing meds)

Latex Eggs/Yolks Sulfites Soy

Please list any other medication and non-medication allergies you may have:

_____

_____

1-4 below for women only: please note that antibiotics may alter the effectiveness of birth control pills. Consult your physician/ OB/GYN for alternative methods of birth control.

1: Is there a possibility of pregnancy? Y or N 2: If yes, Expected delivery date_____

3: Are you nursing? Y or N 4: Are you taking birth control pills? Y or N

I certify I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to the best of my ability. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient:_____ Reviewed by:_____Date:_____

(Parent or guardian if minor)

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental insurance, we will be glad to file dental claims on your behalf. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and other pay a percentage of the charge. **It is your responsibility to pay any deductibles, co-insurances, or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney's fees, and court costs.

Signature of patient:_____ Date:_____

The signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to the doctor(s) of Sandston Comprehensive Dentistry of the benefits otherwise payable to me. In addition, I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient:_____Date:_____