EDISON PARK
SMILES
EST. 2016

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____

Birthdate: _____ Male: ____ Female: ____ Marital Status: _____

SS#: _____ Driver's License: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Best Way to Reach You: _____

How did you hear about us? _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____

PARENT/GUARDIAN INFORMATION

Please fill out this portion if the patient is a minor or if the patient is not the decision maker for their oral health decisions/finances.

Parent/Guardian Name: _____ Birthdate: _____

SS#: _____ Driver's License: _____ Employer: _____

Is demographic information provided above the same? Yes ____ No ____

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Best Way to Reach You: _____

ACCOUNT INFORMATION

Please check which one applies

____ Patient does not have insurance and will pay for services

____ Patient has a primary dental insurance

____ Patient has a primary and secondary dental insurance

____ Other, please explain: _____

PRIMARY INSURANCE INFORMATION

Subscriber's Name: _____ Birthdate: _____

Subscriber's SS#: _____ Subscriber's ID: _____

Relationship to Patient: _____

Please Fill out demographic information, if different from patient's.

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Best Way to Reach You: _____

Insurance Company's Name: _____ Ins Phone #: _____

Employer's Name: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Subscriber's Name: _____ Birthdate: _____

Subscriber's SS#: _____ Subscriber's ID: _____

Relationship to Patient: _____

Please Fill out demographic information, if different from patient's.

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Best Way to Reach You: _____

Insurance Company's Name: _____ Ins Phone #: _____

Employer's Name: _____ Group #: _____

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you require pre-medication before dental visits? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?
- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Other If yes, please explain: _____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

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_____DATE _____

I am an existing patient and have chosen to not answer the health history questions above. I understand that the health questions above that are being asked could be important to my oral health and/or overall health. At this time, there have been no changes in my health history since the last time it was updated..

Date of Last Health History: _____

Signature of Patient, Parent, or Guardian: _____ Date: _____

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Welcome To Our Practice

Our practice is dedicated to Comprehensive Care, and we want you to understand what is going to take place at your visit today.

Digital X-rays: We utilize the latest x-ray technology in our practice to give us the best possible detail while exposing you to the lowest possible amounts of radiation. In our practice, we do believe the judicious use of x-rays is in our patients' best interests. We will do a Panoramic X-ray, which allow us to view any your entire lower and upper jaw and sinuses to identify any issues. Additionally, we will take bitewing x-rays which will be close-up shots of the teeth and bone surrounding your teeth. Here's how we protect you. New digital x-ray equipment reduces the size of the beam, and eliminates "scatter." Digital X-rays require much less exposure time. Lead aprons are almost 100% effective against exposing other parts of your body to radiation.

Oral Cancer Screening: We will do a visual oral cancer screening today for all patients. We will look along the sides of the tongue, under the tongue, along the back of the throat, and over all the soft-tissues of your mouth to check for irregular lesions. We also offer **Early Oral Cancer Detection Screenings** once each year for our patients. We will give you additional information on this screening.

Periodontal Screening: 75% of all Americans have some form of gum disease. Bleeding gums are indicative of **infection of bacteria** under your gums. The bacteria, when allowed to grow under the gum line, will eat away the bone and soft tissue around your teeth, and it is the #1 reason we lose teeth. Your Dentist or Dental Hygienist will do a Periodontal Screening today. We will measure your gums at 6 points around each tooth. You will hear numbers being called aloud during the exam. Numbers of 1,2,or 3 are usually indicative of healthy gums, while any number 4 or more means there is infection present. If there is **not infection** present, we will do a healthy-mouth cleaning for you today.
If infection is found, we will discuss the findings and recommended treatments with you. A healthy-mouth cleaning will NOT treat gum disease, as it only cleans above the gum-line, not below the gums, where the bacterial infection is present. If time allows, we will gladly start the recommended treatment for you today. Typically, these treatments take 1-2 hours.

Comprehensive Exam: The Doctor will examine all of your teeth, gums, and soft-tissues today. Our plan is to work with you, considering your health, cosmetic, and dental needs to develop a treatment plan that best works for your particular conditions.

Please complete the questionnaire on the back page of this sheet, so we can best identify your dental wants and needs.

New Patient Questionnaire

Patient Name: _____

I entered this practice to obtain: (Please check all that apply)

Comprehensive Exam of my entire mouth and a consultation concerning my treatment options.

Smile Design Consultation to learn more about my cosmetic treatment options.

Emergency Exam for a specific area of concern. **Are you in pain?** ____Yes ____ No
Please describe:_____
_____
_____

2nd opinion concerning treatment options presented elsewhere.

Other. Please explain: _____
_____

I would rate the value I place on my oral health as:
_____ Very Important to me
_____ Moderately important to me
_____ Very low importance to me

I would rate the condition of my teeth and gums:
_____ Very good
_____ Good
_____ Acceptable
_____ In need of treatment
_____ In need of a lot of treatment

I would rate my previous dental experiences and quality of care as: _____ Exceptional
_____ Above average
_____ Average
_____ Below Average
_____ Poor

I have concerns in pursing future dental treatment: _____ Yes _____ No

My concerns are:
_____ I am fearful of dental treatment.
Please explain: _____
_____ Financial
_____ Scheduling concerns
Please explain: _____
_____ Other:
Please explain: _____

I consider my smile:
_____ Very appealing
_____ Nice
_____ Acceptable to me
_____ In need of improvement

Is there any further information about you that would help us to assist you more thoroughly?

_____

_____

_____

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Agreement to Receive Electronic Communication (Email and Texting Permission)

This sample form illustrates how a dental practice might obtain patient agreement to receive communications via email.

Patient Name:_____Date of Birth:_____

I agree that the dental practice may communicate with me electronically at the email address and/or texting number below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address. I can withdraw my

consent to electronic communications by calling:

773-631-5200

Email Address (Please Print Carefully): _____

Texting Cell Number (Please Print Carefully): _____

My preferred Method of Contact:

____ Text ____ Phone ____ Email

Patient Signature: _____ Date:_____