PATIENT REGISTRATION

2015 FORM

Today's Dentistry, LLC.

Date____________________

Patient Name ____ **Birthdate**____________________
First Middle Last

Home Address____ **City**______________________ **Zip** _______

Home Number (____) ______________________ **Cell Phone** (___) _________________________________

E- Mail Address ____ **SS#**________________________

I agree that the dental practice may communicate with me electronically at the email address above.

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 communication by calling: 262-375-1800

Whom may we thank for your referral?____

Marital Status: Single___ Married___ Divorced___ Widowed___ Occupation______________________
Patient or Parent/Guardian's Employer _____________________________ Work# (____) ___________________
Business address ____
Spouses or Parent/Guardian's Name________________________ Employer _______________________________
Business address ____

Emergency Contact ______________________________ Relationship _____________ Phone__________________

Person Responsible for Account___________________________ Relationship to patient________________________
Social Security # ________________________ Birthdate_________________ contact #______________________
Home Address (if different) ____ Zip ___________
Is this patient currently a patient in our office? Yes _____ No ______

Do you have dental insurance? Yes_____ No______ Name of Insurance Company __________________________
Group # ______________________ Member ID # __________________________ Policy Holder _________________
Policy Holder Birthdate _________________________ Relationship _______________________________________

If you are without Dental Insurance do you wish to hear about our office "Quality Dental Plan" ? Yes______ No______

DENTAL HISTORY

- When was your last dental visit? ____
- What is your chief dental concern today? ____
- What is the most important thing to you about your teeth? ____
- What would you change about your smile? ____
- Do your gums bleed while brushing or flossing? ____
- Have you been treated for gum disease? ______________if so, when ___________________________________
- Are your teeth sensitive to hot or cold? ____
- Are your teeth sensitive to biting or pressure____
- Do you clench or grind your teeth? _______________ if so, do you wear an appliance? _________________
- Have you had head, neck, or jaw injuries? ____
- Have you had orthodontic treatment? ____
- Are you missing teeth? ____ If so, would you be interested in hearing options for replacement? _______________

MEDICAL HISTORY

Patient name ______________________________________

Physician ____ Phone # ____________________________

Circle yes or no to the following questions:

1. Are you presently under the care of a physician?... Yes No
2. Have you ever had high or low (circle) blood pressure?... Yes No
3. Has a physician ever said you have heart trouble?... Yes No
4. Have you ever had abnormal bleeding following a cut or extraction? .... Yes No
5. Have you ever had a bad reaction to anesthetic (either local or general)? .... Yes No
6. Do you require a premedication of antibiotics prior to dental visits……..……………………………….Yes No
7. Are you allergic to penicillin or any other medication? .... Yes No
   If so, what? ____
8. Are you allergic to anything other than medicine? (e.g. latex or metals)?....................................... Yes No
   If so, what? ____

Do you have or ever had:

1. Rheumatic fever?................................ Yes No
2. Cancer? ………. .... Yes No
3. Anemia or low platelets? .... Yes No
4. Epilepsy or convulsions?..................... Yes No
5. Tuberculosis?...................................... Yes No
6. Asthma or hay fever?........................... Yes No
7. Diabetes? .... Yes No
8. Kidney Trouble?................................. Yes No
9. Liver trouble or jaundice? .... Yes No
10. Thyroid trouble?................................. Yes No
11. Joint Replacement? …………………. Yes No
12. Fainting or dizziness? .... Yes No
13. Glaucoma?.. Yes No
14. Arthritis?... Yes No
15. HIV / AIDS?....................................... Yes No
16. Stroke?.. Yes No
17. Stomach Ulcer? .... Yes No
18. Infective Endocarditis? .... Yes No
19. Prostate Trouble? .... Yes No
20. Hepatitis?.. Yes No
21. Psychiatric Treatment? .... Yes No
22. Do you use tobacco products? .... Yes No
23. Are you pregnant?............................... Yes No

SIGNATURE______________________________________

Have you ever been under the care of a physician for any major illness or injury or hospitalization other than those noted? If so, please list:

____
____

Are you now taking: Please List in space provided

1. Medication for high blood pressure?.............. Yes No
2. Medication for sleep? .... Yes No
3. Radiation therapy? ………………………… Yes No
3. Cortisone, steroids or ACTH? .... Yes No
4. Anticoagulants or blood thinner?.................... Yes No
5. Tranquilizers or sedatives? .... Yes No
6. Antibiotics?... Yes No
7. Insulin?... Yes No
8. Have you ever taken Fen-Phen? .... Yes No

List any other medications:_____________________________
____
____
____
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I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices" (HIPPA).

DATE __________________________________