PATIENT REGISTRATION

Today's Dentistry, LLC.

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

Location Preference Cedarburg West Bend Both

Whom may we thank for your referral?_____

Marital Status: Single___ Married___ Divorced___ Widowed___ Occupation/Student Status_____
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 "Membership Plan" ? Yes_____ No_____

DENTAL HISTORY

- When was your last dental visit? _____
- What is your chief dental concern today? _____
- What is the most important thing 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 (braces)? _____
- 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. Have you ever had abnormal bleeding following a cut or extraction? ..... Yes No
2. Have you ever had a bad reaction to anesthetic (either local or general)? ..... Yes No
3. Have you had a joint replacement, date..... Yes No
4. Have you had an organ transplant, date..... Yes No
5. Have you had a stent placed, date ..... Yes No
4. Do you require a premedication of antibiotics prior to dental visits..... Yes No
5. Are you allergic to Penicillin or any other medication? ..... Yes No
   If so, what? _____
6. Are you allergic to anything other than medicine? (e.g. latex or metals)? ..... Yes No
   If so, what? _____

Do you have now or ever had:

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

Our office is committed to meeting or exceeding the standards of injection control mandated by the OSHA, the CDC and the ADA.

Have you been under the care of a physician for any major illness or injury or hospitalization other than those noted? Please list:

_____

_____

_____

_____

Please list all medications, including vitamins and supplements:
(If you have a printed list, it can be scanned into your chart)

_____

_____

_____

_____

_____

_____

I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices" (HIPPA).

SIGNATURE_____

DATE _____