

PATIENT REGISTRATION

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name you prefer to be called: \_\_\_\_\_ Home Phone \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone \_\_\_\_\_

\_\_\_\_\_ Cell Phone \_\_\_\_\_

\_\_\_\_\_ Drivers License # \_\_\_\_\_

\_\_\_\_\_ SS# \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation \_\_\_\_\_

FT \_\_\_\_\_ PT \_\_\_\_\_ Retired \_\_\_\_\_ Student \_\_\_\_\_ School \_\_\_\_\_ FT/PT \_\_\_\_\_

Referred to us by : \_\_\_\_\_ E-MAIL \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Work # \_\_\_\_\_

SS# \_\_\_\_\_ Employed by: \_\_\_\_\_ Occupation \_\_\_\_\_

Other family members we see: \_\_\_\_\_

Responsible Party (If other than Patient)

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

\_\_\_\_\_ SS# \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Occupation \_\_\_\_\_

Primary Insurance Information (DENTAL)

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Co Name \_\_\_\_\_ Group # \_\_\_\_\_ Member ID # \_\_\_\_\_

Insurance Co Address \_\_\_\_\_ Phone # \_\_\_\_\_

Secondary Insurance Information (DENTAL)

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Co Name \_\_\_\_\_ Group # \_\_\_\_\_ Member ID # \_\_\_\_\_

Insurance Co Address \_\_\_\_\_ Phone # \_\_\_\_\_

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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:

If yes, please list:

- Are you under a physician's care now?       Yes     No \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?     Yes     No \_\_\_\_\_
- Any Stents, Pins, Plates placed in the last 6 months?       Yes     No \_\_\_\_\_
- Have you ever had a serious head or neck injury?             Yes     No \_\_\_\_\_
- Do you use herbal supplements?                                     Yes     No \_\_\_\_\_
- Do you use tobacco?     Yes     No \_\_\_\_\_
- Women: Are you pregnant or trying to get pregnant?       Yes     No      Nursing?  Yes     No
- Taking oral contraceptives/birth control ?     Yes     No
- Are you on a special diet?     Yes     No

Are you taking any medications, pills, or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please list below:
Current Meds	Dose	Reason Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Are you allergic to any of the following?
- Penicillin     Amoxicillin     Aspirin     Codeine     Sulfa     Sulfite     Iodine
- Milk protein     Minocycline     Cephalexin     Hydrocodone     Local Anesthetics
- Acrylic     Latex     Metal     Other: \_\_\_\_\_

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Acid reflux                      | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Liver Disease              |
| <input type="checkbox"/> AIDS/HIV Positive                | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Low Blood Pressure         |
| <input type="checkbox"/> Allergies                        | <input type="checkbox"/> Dry Mouth                 | <input type="checkbox"/> Lupus                      |
| <input type="checkbox"/> Anaphylaxis/Allergic reaction    | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Lung Disease               |
| <input type="checkbox"/> Anemia                           | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Mitral Valve Prolapse      |
| <input type="checkbox"/> Angina                           | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Pacemaker/Defibrillator    |
| <input type="checkbox"/> Arthritis/Gout                   | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Parathyroid Disease        |
| <input type="checkbox"/> Artificial Heart Valve           | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Psychiatric Care           |
| <input type="checkbox"/> Artificial Joints/Knee, Hip, etc | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Radiation Treatments       |
| <input type="checkbox"/> Aspirin Daily                    | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Renal Dialysis             |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Respiratory Problems       |
| <input type="checkbox"/> Blood Disease                    | <input type="checkbox"/> Hearing Problems          | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Blood Thinners                   | <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Chemotherapy                     | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Chest Pains                      | <input type="checkbox"/> Hemophilia                | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Clotting Disorder                | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Cold Sores/Fever Blisters        | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Congenital Heart Disorder        | <input type="checkbox"/> Immune Disease            | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Convulsions                      | <input type="checkbox"/> Irregular Heart Beat      | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Coumadin                         | <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Ulcers                     |

Have you ever had any serious illness not previously listed:  Yes  No Please list below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physicians Name/Phone # \_\_\_\_\_

### DENTAL HISTORY

Previous dentist's name/Phone # \_\_\_\_\_

Approximate length of time since you last had your teeth cleaned & examined \_\_\_\_\_

Date of last full mouth X-Rays \_\_\_\_\_

Reason for your visit to our office \_\_\_\_\_

- Have you ever had complications following dental treatment? .....  Yes  No
- Are you apprehensive about dental treatment? .....  Yes  No
- Do your gums bleed or feel tender or irritated? .....  Yes  No
- Have you ever been diagnosed with periodontal disease? .....  Yes  No
- Have you had scaling & root planing - "deep cleaning"? .....  Yes  No
- Do you feel that you can't open your mouth as wide as you would like? .....  Yes  No
- Does your mouth go to one side when you open? .....  Yes  No
- Do you clench or grind your teeth? .....  Yes  No
- Do you have any teeth that hurt when you chew? .....  Yes  No
- Do you feel your teeth are wearing excessively? .....  Yes  No
- Do you have pain in the jaw joints? .....  Yes  No
- Do you have clicking or popping in the jaw joints? .....  Yes  No
- Do you have headaches, neck aches, shoulder aches? .....  Yes  No
- Have you worn braces on your teeth? .....  Yes  No
- Do you floss regularly? .....  Yes  No
- Does food wedge between your teeth? .....  Yes  No
- Do you have any spaces between your teeth? .....  Yes  No
- Do you dislike the length of your teeth or unhappy with their appearance? ....  Yes  No
- Are you missing any teeth? .....  Yes  No
- If yes, would you like to have the missing teeth replaced? .....  Yes  No
- Would you like your smile to look better or different? .....  Yes  No

Please add anything you feel is important about your dental or medical condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 Date

SIGNATURE ON FILE  
KRISTEN NIEWALD, D.D.S., L.L.C.

\_\_\_\_\_ I authorize the doctor named above to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.

\_\_\_\_\_ I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.

\_\_\_\_\_ I authorize my doctor to act as my agent in helping me obtain payment from my Ins. Co.

\_\_\_\_\_ I authorize payment of health benefits otherwise payable to me, directly to my doctor.

\_\_\_\_\_ I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me. Any portion of services not covered by insurance will be paid at the time of services rendered. This includes my annual deductible and co-pays.

\_\_\_\_\_ I understand that I will be charged a fee of \$75.00 for failed appointments. I will contact Dr. Niewald's office within 24 hours to change an appointment.

\_\_\_\_\_ I permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_ I agree that this authorization applies to all of my dependents.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name

PERMISSION TO SHARE MY HEALTH INFORMATION  
(Example: Spouse or Parent)

I, \_\_\_\_\_, give Dr. Kristen Niewald and Staff my full consent to discuss my dental health and treatment with \_\_\_\_\_.

\_\_\_\_\_  
Signature