



# Patient Registration Form

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Sex:  MALE  FEMALE Home Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Status:  SINGLE  MARRIED  PARTNERED  OTHER Cell: \_\_\_\_\_

email: \_\_\_\_\_ Work Phone: \_\_\_\_\_

By providing us your email you consent and accept the risk in receiving information via email.

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact

In an emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

**Is patient responsible for payment: Y or N**

**Is patient the policy holder: Y or N**

Name of responsible party/policy holder: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Address: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Tel: \_\_\_\_\_

\_\_\_\_\_ email: \_\_\_\_\_ cell: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driv Lic: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer \_\_\_\_\_ Employer address: \_\_\_\_\_

Insurance Group Union Local  
Company: \_\_\_\_\_ Number: \_\_\_\_\_ Number: \_\_\_\_\_

Insurance  
Address: \_\_\_\_\_

**Additional Insurance:**

Name of responsible party/policy holder: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Address: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Tel: \_\_\_\_\_

\_\_\_\_\_ email: \_\_\_\_\_ cell: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driv Lic: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer \_\_\_\_\_ Employer address: \_\_\_\_\_

Insurance Group Union Local  
Company: \_\_\_\_\_ Number: \_\_\_\_\_ Number: \_\_\_\_\_

Insurance  
Address: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

\*\*You May Refuse to Sign This HIPAA Portion of the Acknowledgement\*\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CANCELLATION/INSURANCE POLICY**

I have read, understood and accept the terms of the outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Skye Cosmetic Dental Center. I am fully aware that I am the final responsible party for these commitments. I am also aware that any cancellations or reschedules made within 48 hours of the appointment time will result in a nominal charge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CONSENT FOR TREATMENT**

I hereby authorize doctor/staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

For office Use Only

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be acquired because: Individual refused to sign, communications barriers prohibited obtaining acknowledgement, or Other (please specify):

\_\_\_\_\_

Employee Name \_\_\_\_\_ Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

# DENTAL HISTORY



Name \_\_\_\_\_ Nickname \_\_\_\_\_

Referred by \_\_\_\_\_

How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor

Previous Dentist \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_ Mos/Yrs

Date of most recent dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent xrays \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of most recent treatment (other than a cleaning) \_\_\_\_/\_\_\_\_/\_\_\_\_

I routinely see my dentist every:  3 mo.  4 mo.  6 mo.  12 mo.  Not routinely.

WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:**

**YES NO**

**PERSONAL HISTORY**

1. Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10(most) [\_\_\_\_] \_\_\_\_\_  YES  NO
2. Have you had an unfavorable dental experience? \_\_\_\_\_  YES  NO
3. Have you ever had complications from past dental treatment? \_\_\_\_\_  YES  NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_  YES  NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_  YES  NO
6. Have you had any teeth removed? \_\_\_\_\_  YES  NO

**GUM AND BONE**

7. Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_  YES  NO
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_  YES  NO
9. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_  YES  NO
10. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_  YES  NO
11. Have you ever experienced gum recession? \_\_\_\_\_  YES  NO
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_  YES  NO
13. Have you experienced a burning sensation in your mouth? \_\_\_\_\_  YES  NO

**TOOTH STRUCTURE**

14. Have you had any cavities within the past 3 years? \_\_\_\_\_  YES  NO
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_  YES  NO
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_  YES  NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? \_\_\_\_\_  YES  NO
18. Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_  YES  NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_  YES  NO
20. Do you frequently get food caught between any teeth? \_\_\_\_\_  YES  NO

**BITE AND JAW JOINT**

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_  YES  NO
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? \_\_\_\_\_  YES  NO
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_  YES  NO
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_  YES  NO
25. Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_  YES  NO
26. Are your teeth developing spaces or becoming more loose? \_\_\_\_\_  YES  NO
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? \_\_\_\_\_  YES  NO
28. Do you place your tongue between your teeth or rest your teeth against your tongue? \_\_\_\_\_  YES  NO
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_  YES  NO
30. Do you clench your teeth in the daytime or make them sore? \_\_\_\_\_  YES  NO
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? \_\_\_\_\_  YES  NO
32. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_  YES  NO

**SMILE CHARACTERISTICS**

33. Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_  YES  NO
34. Have you ever whitened (bleached) your teeth? \_\_\_\_\_  YES  NO
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? \_\_\_\_\_  YES  NO
36. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_  YES  NO

Patient's Signature: \_\_\_\_\_

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

Doctor's Signature: \_\_\_\_\_

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

# MEDICAL HISTORY



Name \_\_\_\_\_ Nickname \_\_\_\_\_

Name of Physician/and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health?  Excellent  Good  Fair  Poor

**DO YOU HAVE or HAVE YOU EVER HAD:**

	YES	NO		YES	NO
1. hospitalization for illness or injury? _____	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____			28. autoimmune disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			(i.e. rheumatoid arthritis, lupus, scleroderma)		
<input type="checkbox"/> penicilin			29. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa			32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			37. STI / STD / HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	38. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	42. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43. emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol / recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>ARE YOU:</b>		
13. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	(i.e. fever, chills, new cough, or diarrhea)		
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	53. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54. considered a touchy / sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c=_____) _____	<input type="checkbox"/>	<input type="checkbox"/>	56. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	57. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>	58. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
26. osteoporosis/osteopenia (i.e. taking bisphosphanoates) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature: \_\_\_\_\_

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

Doctor's Signature: \_\_\_\_\_

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