Patient Registration

PLEASE PRINT

Patient Information

Patient Name: ____ Social Security #: _ _ _/_ _/_ _ _ _
First *MI* *Last*

Address: ____City:_____________ ST___ Zip:__________

Phone: *(HM)* _____________________ *(WK)* __________________ext.___ *(Cell)* __________________

Email Address: ____**Date Of Birth**: _ _/_ _/_ _ _ _

Sex: M / F **Status:** ____Married ____Single ____ Divorced ____Separated ____Widowed

Whom may we thank for referring you to our practice? ____

Medical History

Health problems that you may have, or medications that you are taking, could have an affect on the dental treatment that you will receive. Thank you for answering the following questions.

Allergies to any of the following: ____Latex ____Aspirin ____Penicillin ____Codeine ____Acrylic ____Metal ____Local Anesthetics ____Other (please explain)____

Medications: ____

Primary care Physician _________________________Hospital _________________ Phone# ______________

Have you ever been hospitalized or had a major operation? No / Yes _____________________________

Have you ever had a serious head or neck injury? No / Yes _____________________________

Have you ever had any serious illness? No / Yes _____________________________

Are you on a special diet? No / Yes

Do you use tobacco? No / Yes _______________ Do you use controlled substances? No / Yes______________

Have you had: ___Subacute Bacterial Endocarditis ___Heart Transplant ___Artificial Heart Valve ___Congenital Heart Defect (excluding Mitral Valve Prolapse)

Please check all that apply

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Angina
- ☐ Artificial Joint:_______________
  *Date:*_______________
- ☐ Asthma
- ☐ Cancer
  Type:_______________
- ☐ Chemotherapy(current & past)
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Diabetes: Insulin/Diet controlled
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Glaucoma
- ☐ Heart Pace Maker
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Jaw Pain: Injury / clicking
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Psychological Disorders
- ☐ Nervous Disorders
- ☐ Pregnancy
  Due date: _____________
- ☐ Radiation Treatments
  Location:_____________
- ☐ Renal Dialysis
- ☐ Respiratory Problems
- ☐ Sinus Trouble
- ☐ Stroke date: ___________
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

☐ *Other:*____

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 change in medical status.

X____**Date:** ______________

I have read and understand this office's Notice of Privacy Practices (HIPPA).

X____**Date:** ______________

Account Information

(Person Responsible for Account)

☐ ***Check if same as front page***

Name: ____________________________________ SS# _ _ _/_ _/_ _ _ _ Date of Birth: _ _/_ _/ _ _ _ _
Billing Address if different: ___________________ ____
____
City *State* *Zip*
Relation: _______________ Home #: _____________________ Other Phone#: ____________________

Employer Name: ____ Work Phone#: __________________

Insurance Information

1.)<u>Primary Dental Insurance</u>

☐ ***Check if same as front page and continue down to Company Name***

Name: _____________________________________ SS# _ _ _/_ _/_ _ _ _ Date of Birth: _ _/_ _/ _ _ _
Billing Address: ____
____
City *State* *Zip*
Relation to: _______________ Home #: _____________________ Other Phone#: ____________________

****Insurance Company**:*____
Address: ____
____
City *State* *Zip*

*Phone:*_______________ *Insured Id#* ____________________________ *Group #* __________________

2.)<u>Secondary Dental Insurance</u>

Name: _____________________________________ SS# _ _ _/_ _/_ _ _ _ Date of Birth: _ _/_ _/_ _
Billing Address: ____
____
City *State* *Zip*
Relation to: _______________ Home #: _____________________ Other Phone#: ____________________

****Insurance Company**:*____
Address: ____
____
City *State* *Zip*

*Phone:*_______________ *Insured Id#* ____________________________ *Group #* _________________

New Patient Questionnaire

1. Please tell us what brought you to our office today.

   ____

2. What is your primary dental concern?

   ____

3. When was your last cleaning and exam? ______________________________________
4. When was the last time you had x-rays taken? ________________________________
5. Would you be able to have x-rays forwarded to us? NO / YES
6. Have you ever had orthodontic treatment? NO / YES *(when)* __________________
7. Have you had your wisdom teeth removed? NO / YES *(when)* __________________
8. Do you experience any of the following:
   - ☐ Sensitive teeth, hot/cold, sweets
   - ☐ Sensitive teeth to pressure or biting
   - ☐ Bleeding gums
   - ☐ Clenching or grinding teeth
   - ☐ Pain in your jaw joint or muscle of the head or neck area.
9. How did you hear about Kirk Dental?____

Is there anything in particular you would like us to know about your dental needs?

____

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____

Is there anything in particular we can do to make your visit here comfortable?

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