



16TH AVENUE DENTAL
Family dentistry from the heart

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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____
First Name Middle Initial Last Name Preferred Name
Birth Date (MM/DD/YYYY): ___/___/____ Sex: M F Marital Status: Married Single Child Other
Address: _____ City: _____ Postal Code: _____
Phone Number: (Cell) _____ (Home) _____ (Work) _____ Ext. _____
Email: _____ The best way to reach you: Cell Home Work Email
Employer: _____ Occupation: _____
For minor children, who is responsible for this account? _____
Name and Phone Number of Emergency Contact: _____
Are you available to come for appointments on short-notice? If Yes, Availability: _____ Yes No
Preferred Appointment: *TIME* Morning Afternoon Evening Anytime
DAY OF WEEK Monday Tuesday Wednesday Thursday Friday

INSURANCE INFORMATION

<p>PRIMARY: Name of Insured: _____ Is insured a patient? <input type="checkbox"/>Yes <input type="checkbox"/>No Insurance Plan Name: _____ Insured's Birth Date (MM/DD/YYYY): ___/___/____ ID #: _____ Group #: _____</p>	<p>SECONDARY: Name of Insured: _____ Is insured a patient? <input type="checkbox"/>Yes <input type="checkbox"/>No Insurance Plan Name: _____ Insured's Birth Date (MM/DD/YYYY): ___/___/____ ID #: _____ Group #: _____</p>
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REFERRAL INFORMATION

How did you hear about us? Friend/Family School Sign Flyer Website Online Other _____
Whom can we thank for referring you to our practice? _____
Is another family member currently a patient here? If "Yes", name of patient: _____ Yes No

APPOINTMENT POLICY

In order to be fair to both our team members and to all of our patients, we do require at least two business days (48 hours) notice for any appointment changes or cancellations. Failure to provide this notice will result in a \$60.00 per hour missed appointment charge. Please help us serve you better by keeping scheduled appointments as this time is reserved for you. **If multiple appointments are missed, a non-refundable fee will be charged prior to booking another appointment.**
Please Initial: _____

CONSENT FOR SERVICE

I, the Patient/Parent/Guardian, authorize for 16TH AVENUE DENTAL to take x-rays, study models, photos, or any other diagnostic aids deemed appropriate by the Doctor in order to diagnose and develop a treatment plan for me. I also authorize the Doctor to perform any and all forms of treatment, medications, and therapy that may be indicated as mutually agreed upon. I understand that during a procedure, circumstances may dictate a change in technique or additional fees which I am responsible for. The most common being root canal therapy following routine restorative procedures, I authorize the Doctor to make any changes to my treatment plan as necessary. The below signature also authorizes 16TH AVENUE DENTAL to forward any patient information or records, which includes my Health History, x-rays and photos to any office which I may be referred to for further treatment.

Patient Name: _____ Signature of Patient/Parent/Guardian: _____
Date: _____ Relationship to Patient: _____

DENTAL HISTORY

Patient Name: _____ Birth Date (MM/DD/YYYY): ___/___/_____ Sex: M F
 Previous Dentist: _____ How long have you been a patient? ___ months years
 Date of last dental exam (MM/DD/YYYY): ___/___/_____ Date of last x-rays (MM/DD/YYYY): ___/___/_____

I routinely see my dentist every 3 months 6 months 9 months 12 months not routinely

What is your chief concern today? _____
 How often do you brush? _____ How often do you floss? _____
 Please rate your level of anxiety to dental treatment from 1 (Least) to 10 (Most): _____

Have you had an unfavorable dental experience? If Yes, describe: _____ Yes No
 Have you ever had complications from past dental treatment? If Yes, describe: _____ Yes No
 Have you ever had trouble getting numb or had any reactions to local anesthetic? Yes No
 If Yes, please provide details: _____

How can we make your dental appointments more comfortable? _____
 Are you unhappy with how your teeth look? If Yes, what would you change? _____ Yes No

Do you currently have or have had any of the following? (**Please check all that apply to you**):

<input type="checkbox"/> Cavities within past 3 years	<input type="checkbox"/> Grinding/clenching habit	<input type="checkbox"/> Bad taste/odor in the mouth
<input type="checkbox"/> Sensitivity to sweets/hot/cold/biting	<input type="checkbox"/> Pain in TMJ/locking jaw	<input type="checkbox"/> Surgery in the mouth
<input type="checkbox"/> Food catches between teeth	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Severe gagging
<input type="checkbox"/> Injury to teeth/jaw	<input type="checkbox"/> Orthodontic treatment	<input type="checkbox"/> Cold sores/ulcers/swelling in mouth
<input type="checkbox"/> Dental extraction	<input type="checkbox"/> Gum recession	<input type="checkbox"/> Denture
<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Bleeding gums when flossing/brushing	<input type="checkbox"/> Sleep apnea/snoring

Please provide details of any positive answers above: _____

MEDICAL HISTORY

Date of last physical exam: _____ Physician/Specialty: _____ Tel: _____
 How would you rate your general health? Excellent Good Fair Poor
 Do you smoke tobacco? If Yes, what type and how often? _____ Yes No
 Do you have or have you had, any of the following medical conditions? (**If yes, please check**):

<input type="checkbox"/> Abnormal bruising or bleeding	<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory disease
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Hepatitis A, B or C	<input type="checkbox"/> Rheumatic fever/Rheumatic heart disease
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Cortisone treatments/steroids	<input type="checkbox"/> Heart murmur/prolapsed valve	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Asthma, Sinus Problems	<input type="checkbox"/> Diabetes (Type: _____)	<input type="checkbox"/> High/Low blood pressure	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Jaundice/Liver disease	<input type="checkbox"/> Skin disease or rash
<input type="checkbox"/> AIDS/HIV positive	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Back problems	<input type="checkbox"/> Eye disorder/Glaucoma	<input type="checkbox"/> Nervous disorders	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Blood disorders (eg. Anemia)	<input type="checkbox"/> Fainting	<input type="checkbox"/> Pacemaker (Year placed: _____)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer (Type: _____)	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Prosthetic Heart Valve	<input type="checkbox"/> Tumors, cysts or growths
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hearing problem	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Ulcer/Digestive disorder
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Heart disease (describe below)	<input type="checkbox"/> Radiation treatment	

Please provide details of medical condition: _____

Allergies: NONE Aspirin Codeine Latex Local Anesthetic Penicillin Sulfa Other: _____

Are you currently or have you ever taken bisphosphonates? (eg. Fosamax, Zometa) Yes No
 Are you currently taking any blood thinners? (eg. Aspirin, Warfarin, Plavix, Heparin, Eliquis, Pradaxa, Xarelto) Yes No
 Are you required to take antibiotics prior to dental treatment? If Yes, Reason: _____ Yes No

****LIST ALL MEDICATIONS, SUPPLEMENTS, VITAMINS, RECREATIONAL DRUGS AND/OR HERBS YOU ARE CURRENTLY TAKING:**

DRUG	PURPOSE	DRUG	PURPOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

****Please advise us in the future of any changes in your medical history or any new medications you may be taking**

Have you had a serious illness, operation or been hospitalized in the last 5 years? Yes No
 If Yes, what was the illness or problem? _____

Do you have any surgeries planned in the future? If Yes, describe: _____ Yes No

[WOMEN ONLY] Are you: Pregnant (Expected Delivery Date: _____) Nursing Taking birth control pills

Signature of Patient/Parent/Guardian: _____ Date: _____ Doctor's Initials: _____