Mendelson Family Dentistry

PATIENT REGISTRATION FORM

☐Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female Date _____

PATIENT NAME: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
PHONE: Home: _____ Cell: _____
Work: _____ Pager: _____
Email: _____

Social Security Number: _____
Occupation: _____ Employer Name: _____
Address: _____
Emergency Contact Name and Number: _____
_____
Relationship: _____
Marital Status: ☐Married ☐Single ☐Divorced ☐ Single ☐Widowed
Whom may we thank for referring you? _____

Party Responsible for Payment:
Name: _____ Phone: _____
Home Address: _____
_____
Employer: _____ Phone: _____

Signature: _____ (Patient/Parent/Guardian)
This information is accurate to the best of my knowledge. I am aware that I am ultimately responsible for any services provided by Mendelson Family Dentistry and that there is a service charge for any unpaid balance over 90 days.

Primary Dental Insurance Information: (If applicable)
Group/Employer Name: _____ Group #:_____
Insurance Co. Name: _____ Phone #: _____
Address: _____
Employee (Policy Holder):_____
Relationship to Patient: _____
Subscriber ID #: _____
Policy Holder Birthday: _____ Policy Holder SS#: _____

Secondary Dental Insurance Information:
Group/Employer Name: _____ Group #:_____
Insurance Co. Name: _____ Phone #: _____
Address: _____
Employee (Policy Holder):_____
Relationship to Patient: _____
Subscriber ID #: _____
Policy Holder Birthday: _____ Policy Holder SS#: _____

Health History

Date of last dental examination:_____ Dentist's Name: _____
Date of last dental x-rays: _____ Date of last Physical exam: _____
Physician's Name_____
Have you been hospitalized in the past two years?:_____
Please list all medications you are currently taking, including over the counter, vitamins and herbal remedies:

_____
_____
What is the purpose of your visit today? _____

☐Yes ☐No Are you having pain or discomfort at this time?
☐Yes ☐No Do you feel nervous about having dental treatment?
☐Yes ☐No Have you ever had a bad experience in a dental office?
☐Yes ☐No Is there anything that you dislike about your smile?
☐Yes ☐No Are there any growths or sores in or around your mouth?
☐Yes ☐No Do you have trouble chewing?
☐Yes ☐No Does food catch between your teeth?
☐Yes ☐No Do you have pain in or near your ears?
☐Yes ☐No Have you ever been told that you have gum problems?
☐Yes ☐No Do you now have bleeding gums or any other gum conditions?
☐Yes ☐No Do you like the appearance of your teeth?
☐Yes ☐No Do you like the color of your teeth?
☐Yes ☐No Do you suffer from headaches?
☐Yes ☐No Do you have a history of TMJ disorder?
☐Yes ☐No Do you require antibiotics before dental work?
☐Yes ☐No Do you brush and floss daily?
☐Yes ☐No Do you or have you been told that you snore?
☐Yes ☐No Have you been diagnosed with sleep apnea?
☐Yes ☐No Are your teeth sensitive to hot, cold or anything else?
☐Yes ☐No Do you experience bad breath?

Are you allergic to or made sick by:
Codeine ☐Yes ☐No
Penicillin ☐Yes ☐No
Aspirin ☐Yes ☐No
Latex ☐Yes ☐No
Metals ☐Yes ☐No
Local Anesthetics ☐Yes ☐No
Other Meds/ Allergies ☐Yes ☐No
Please Explain _____

Do you have a history of:

☐ Yes ☐ No Heart Attack/ Disease
☐ Yes ☐ No Heart Failure
☐ Yes ☐ No Angina Pectoris
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Mitral Valve Prolapse *
☐ Yes ☐ No Congenital Heart Lesions *
☐ Yes ☐ No Heart Murmur *
☐ Yes ☐ No Heart Surgery
☐ Yes ☐ No Heart Pacemaker
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Bleeding Disorder
☐ Yes ☐ No Any type of transplant *
☐ Yes ☐ No Sickle Cell Disease
☐ Yes ☐ No Bruise Easily
☐ Yes ☐ No Anemia
☐ Yes ☐ No HIV positive, ARC AIDS
☐ Yes ☐ No Rheumatic Fever*
☐ Yes ☐ No Cancer (Type: _____)
☐ Yes ☐ No Radiation treatment
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Liver Disease

☐ Yes ☐ No Chemotherapy
☐ Yes ☐ No Any type of implant *
☐ Yes ☐ No Cortisone medicine
☐ Yes ☐ No Artificial joint *
☐ Yes ☐ No Kidney Disorder
☐ Yes ☐ No Epilepsy or seizures
☐ Yes ☐ No Fainting or Dizzy spells
☐ Yes ☐ No Psychiatric treatment
☐ Yes ☐ No Hepatitis (type: _____)
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Use tobacco products
☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Allergies or Hives
☐ Yes ☐ No Asthma
☐ Yes ☐ No Hay Fever
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Cold sores
☐ Yes ☐ No Alcoholism

Antibiotic premedication may be required prior to your appointment.

Women:
Are you pregnant? ☐ Yes ☐ No If yes, due date: _____
Are you taking birth control pills? ☐ Yes ☐ No
Please be aware that antibiotics could cause birth control pills to be ineffective.

☐ Yes ☐ No Is there anything related to your medical or dental history that you have not indicated above? If yes please explain:

_____

_____

The following are current policies in effect for patients of Mendelson Family Dentistry:

1. All insurance co-pays, deductibles and personal payments are due at the time of your visit. If you elect to do a procedure not covered by your insurance, you are responsible for all charges incurred for the procedure.
2. You must present a current active insurance card at the time of your visit. If you do not have your insurance card, payment of the procedure is due in full on the date of service and can be submitted to your insurance company upon proof of insurance.
3. All accounts 90 days past due will be charged 1.5% interest rate per month until the balance is paid in full.
4. If your insurance lapses or you do not have active coverage you are responsible for all charges incurred while you are without insurance.
5. Self-pay parties must pay at the time of service. Financing is available through Care-Credit.
6. To cancel an appointment, you MUST give at least 24-hour notice or a $75 cancellation fee will be assessed.
7. If you miss three or more appointments without providing advance notice, you will only be seen for emergency appointments.

_____ _____

Signature Date