Palmer & O'Brien Family Dentistry

PATIENT REGISTRATION

Welcome to our office. Thank you for providing the following confidential information.

Name_____ Home Telephone_____

Mailing Address_____ Place of Employment _____

City and State _____ Office Telephone _____

Zip Code_____ Cell or Alternate _____

Date of Birth _____ Male___ Female___ Social Security_____

Email Address _____ Would you like to receive email and text message reminders? Y/N

How did you hear about us?

☐Internet ☐Insurance Co. ☐Our website ☐Sign ☐Existing Patient_____

☐Other _____ (Name)

Emergency Contacts_____

In case of emergency, notify _____Relationship_____

Home Telephone _____ Alternate_____

Payment Information_____

Name of responsible party (if other than patient) _____

Address _____ **Method of Payment**

City, State, Zip _____ Cash/ Check _____

Home Telephone _____ Mastercard/ Visa_____

Dental Insurance (Primary)

Insured's Name _____

Insured's D.O.B. _____

Insured's SS No. _____

Place of Employment _____

Insurance Co. _____

Dental Insurance (Secondary)

Insured's Name _____

Insured's D.O.B. _____

Insured's SS No._____

Place of Employment _____

Insurance Co. _____

Consent

The undersigned hereby authorizes the Doctor and Hygienist to take X-rays, study models, Photographs, or any other diagnostic aids deemed appropriate by the Doctor's thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated and understand the use of anesthetic agents embodies a certain risk. **I understand that my dental insurance is a contract between me and the insurance carrier, and not the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless financial agreements have been made.** I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be applied to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be applied added to any overdue balance. **There will be a $ 25.00 fee for any appointment that is not canceled without a 24-hour notice.**

Signature: _____ Date: _____

MEDICAL HISTORY

Do you have or have any of the following:

- ❑ Valve or Joint Replacement
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Mitral Valve Prolapse
- ❑ Heart Disease
- ❑ Angina Pectoris
- ❑ Bleeding Problems
- ❑ Cigarette, Pipe or Cigar Smoking
- ❑ Asthma
- ❑ Diabetes
- ❑ Epilepsy or Seizures
- ❑ Kidney Disease
- ❑ Ulcers
- ❑ Hepatitis/Liver Disease
- ❑ Tuberculosis
- ❑ Blood Transfusions
- ❑ Latex Sensitivity
- ❑ Dry Mouth
- ❑ Aids/HIV Positive
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Anemia
- ❑ Stroke
- ❑ Sinus Problems
- ❑ Radiation Treatment
- ❑ Chemical Dependency
- ❑ Allergies to Anesthetics
- ❑ Arthritis

WOMEN: Are you Pregnant: ❑Yes ____ Months ❑ No Nursing: ❑ Yes ❑ No Taking Birth Control pills? ❑ Yes ❑ No

List any other significant medical history _____

DENTAL HISTORY

Do you have or have you had:

- ❑ Tooth sensitivity to heat, cold, sweets, or pressure
- ❑ Food impaction between teeth
- ❑ A reaction to a dental injection
- ❑ Bleeding gums
- ❑ Loose teeth
- ❑ Orthodontic (braces) treatment
- ❑ Headaches, earaches, or popping of you jaw
- ❑ Complications from dental extractions
- ❑ Periodontal (gum) disease or treatment

Are you satisfied with the appearance of your teeth and smile? ❑ Yes ❑ No

If not, would you like:

- ❑ Whiter teeth
- ❑ Straighter teeth
- ❑ To close spaces between teeth
- ❑ Have silver fillings replaced with tooth-colored restorations

❑ Other desired improvements:

_____

_____

Reason for seeing the Doctor today: _____

Date of: Last dental visit: _____ Last dental cleaning: _____ Last full mouth x-rays: _____

Your previous Dentist's name: _____

Do you feel nervous about having dental treatment? ❑ Yes ❑ No

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? ❑ Yes ❑ No

If yes, describe: _____

Is there anything else about having dental treatment you would like us to know?

_____

MEDICATIONS

Current Medication	Reason for Taking	Current Medication	Reason for Taking

Medications you are allergic to: _____

I attest that to the best of my knowledge the information provided above is accurate and complete. Any changes in health status or medications will be reported to the Doctor at the next dental visit following the change.

Signature: _____ ❑ Patient ❑ Parent ❑ Guardian