

REGISTRATION PATIENT INFORMATION

Last Name _____ First Name _____ MI _____
Birthdate _____ Marital Status _____ Male/Female _____
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
May we contact you by email? Y / N Email address _____
Are you a full time student? If so, where? _____
If patient is a child _____
Mother's name and birthdate _____ Father's name and birthdate _____

Whom may we thank for referring you to our office? _____

BILLING INFORMATION / PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relationship to patient _____ SS# _____
Employer _____ Office Phone _____ Ext. _____
Employer's Address _____ City _____ State _____ Zip _____
Years with firm _____ Position _____

SPOUSE INFORMATION RELATING TO PATIENT (IF MARRIED)

Name _____ Employer _____ Work Phone _____
Employer's Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____ Home Phone _____ Work Phone _____
Home Address _____ City _____ State _____ Zip _____

DENTAL INSURANCE

Primary:

Policyholder's Name _____ Policyholder's Birthdate _____ SS#/ID# _____
Policyholder's Address _____ Work Phone _____
Employer _____ Name of Insurance Plan/Address _____ Group # _____

Secondary:

Policyholder's Name _____ Policyholder's Birthdate _____ SS#/ID# _____
Policyholder's Address _____ Work Phone _____
Employer _____ Name of Insurance Plan/Address _____ Group # _____

MEDICAL INSURANCE

Policyholder's Name _____ Policyholder's Birthdate _____ SS#/ID# _____
Policyholder's Address _____ Work Phone _____
Employer _____ Name of Insurance Plan/Address _____ Group # _____

I certify that I/my dependents have insurance coverage and assign directly to Ling Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I authorize release of any information relating to this claim. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I agree to pay fees and expenses incurred by Ling Family Dentistry to collect on this account. I understand that all balances 60 days and older are subject to interest at 1.5% monthly / 18% annually. It is agreed and understood that if this obligation should become delinquent that I, the patient or guarantor party, agree to pay the collection costs and any costs associated with placing my obligation to a collection agency and/or to an attorney for litigation. I authorize you to check my credit and employment history.

Signature _____ Date _____

MEDICAL HISTORY

Last Name _____ First _____ MI _____ Date of Birth _____

Your Physician _____ Address _____ Phone _____

Former Dentist _____ Address _____ Phone _____

YES NO

- 1. Are you now under current medical treatment? Explain _____
- 2. Have you had any recent medical surgeries? Explain _____
- 3. Are you currently taking any medication? List _____
- 4. Do you have any allergies? (penicillin, codeine, any other) Explain _____
- 5. Do you have a heart murmur, heart valve defect or any heart conditions? Explain _____
- 6. Do you have any circulatory problems? (high or low blood pressure, etc.) Explain _____
- 7. Are you a hemophiliac or have you had any bleeding problems? Explain _____
- 8. Are you pregnant? Due date _____
- 9. Have you ever had any x-ray/radiation treatment to the head and neck area? Explain _____
- 10. Have you ever experienced any complications with healing? Explain _____
- 11. Have you ever had a hip or joint replacement? Explain _____
- 12. Have you ever taken Oral or IV Bisphosphonates for Osteoporosis (Fosamax, Boniva, etc.) _____

YES NO

- Blood disease (anemia, etc.)
- Nervous disorders
- Respiratory disorders (asthma, etc.)
- Arthritis or rheumatism
- Diabetes
- Tobacco use
- Latex Sensitivity
- Sinus problems
- Chronic ear infections
- Thyroid problems
- Other _____

YES NO

- Tuberculosis
- Epilepsy
- Rheumatic fever
- Tumors or growths
- Liver disease (jaundice, etc.)
- Kidney disease
- Serious head injuries
- Acq. Immune Deficiency Synd. (AIDS/HIV)
- Hepatitis
- Mitral Valve Prolapse
- Surgical Implant

In the unlikely event that a Ling Family Dentistry healthcare worker is exposed to my blood or body fluids through a needle stick, skin cut, or splash to the eyes/mouth area, I agree to have my blood tested (free of charge) for blood borne diseases to include Hepatitis and Human Immunodeficiency Virus (HIV). Yes - No

DENTAL HISTORY

YES NO

- 1. Do you take premedication for dental treatment?
- 2. Do you have a toothache now?
- 3. Do you have any growths or sores in your mouth?
- 4. Do your gums bleed easily?
- 5. Is any part of your mouth sore to pressures (including biting) or irritants? (cold, heat, sweets, etc.)
Explain _____
- 6. Have you ever had local anesthetic (novocaine)?
- 7. Have you ever had any adverse reactions to local anesthetics?
- 8. Have you ever had any difficulty with dental extractions in the past? (prolonged bleeding, dry socket, etc.)
Explain _____
- 9. Have you ever had periodontal disease or gum disease? Explain _____
- 10. Do you habitually clench or grind your teeth during the day or night?
- 11. Do you have pain in or near your ears?
- 12. Have you ever been instructed in proper flossing and brushing techniques?
- 13. Do you brush daily?
- 14. Do you floss daily?
- 15. Do you have fluoride in your water supply?
- 16. Date of last dental examination _____ Date of last full mouth x-ray examination _____

Initial:										
Date:										

Signature Date