WELCOME TO GREENWOOD DENTAL CARE

DENTAL REGISTRATION AND HISTORY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Today's Date: ____________

PATIENT INFORMATION

Name: ____ ❑ Male ❑ Female
Last First MI

I Prefer to be called: ____________________ Birthdate: ___/___/___ Age: ______ SS#:________________
Address: ______________________________________ City: ________________ State: _______ Zip: _________
Home Phone: _________________ Work Phone: ____________________ Cell phone: ______________________
E-Mail Address: ___________________________ Do you own a Home ❑ Yes ❑ No ❑ Rent
Employer: _________________________ Occupation: ______________________ No. of Yrs at this Job: ________

PERSON RESPONSIBLE FOR ACCOUNT (If Different than above)

Name: ____ ❑ Male ❑Female
Last First MI

Relationship to Patient: ❑Self ❑Spouse ❑ Child ❑ Parent ❑ Other ____________________
Address: ______________________________________ City: ________________ State: _______ Zip: ________
Do you own a Home ❑ Yes ❑ No ❑ Rent Home Phone: _________________ Cell phone: _______________
E-Mail Address: ___________________________ Work Phone: _________________________
Employer: _________________________ Occupation: ______________________ No. of Yrs at this Job: ________
Birthdate: ___/___/___ Age: ______ SS#:___________________

SPOUSE INFORMATION

His/Her Name: ______________________________
Employer: ____________ No. Yrs employed: _______
Occupation: ______________ SS#: ______________
Wk. #: (   )______________ Birthdate: ___________

EMERGENCY INFORMATION

Name: __________________ Phone #: ____________
Address: ____
City: ____________ State: ______ Zip: ____________
Relation to Patient: _________________________________

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insurance Co. Name: __________________________ Insurance Co. Phone #: ________________________
Insurance Co. Address: ____
Group # (Plan, Local or Policy #): ____
Insured's Name: ______________________________ Relation: ____________________________________
Insured's Birthdate: ___/____/___ Insured's ID#: __________________ Insured's Employer: ________________

DENTAL INSURANCE INFORMATION (Additional/Secondary Carrier)

Insurance Co. Name: __________________________ Insurance Co. Phone #: ________________________
Insurance Co. Address: ____
Group # (Plan, Local or Policy #): ____
Insured's Name: ______________________________ Relation: ____________________________________
Insured's Birthdate: ___/____/___ Insured's ID#: __________________ Insured's Employer: ________________

I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that payment is due in full at the time of treatment unless prior arrangements have been approved. All unpaid accounts will be subject to an annual interest rate of 18% to be attached after a grace period of 90 days.

____ ___________________________________

PATIENT SIGNATURE (Parent of Child) **Date**

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

MEDICAL HISTORY

Are you currently under the care of a physician? **Y / N**

If yes, please Explain: ______________________________

Physician's Name: ______________________________

Phone #: ______________________________

Women:

- Are you taking birth control pills?- ❑
- Are you pregnant? ------------------- ❑
- Are you nursing? --------------------- ❑

Are you taking any prescriptions, over-the-counter medications, vitamins or supplements? **Y / N**

Please list each one: ______________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? **Y/ N**

Have you ever had any of the following diseases, medical problems or habits?

Abnormal Bleeding ------	❑	Heart Murmur-----------------	❑	Rheumatic / Scarlet Fever----	❑
Alcohol / Drug Abuse---	❑	Heart Surgery --------------	❑	Seizure Disorder--------------	❑
Anemia----------------------	❑	Hepatitis------------------------	❑	Sickle Cell Disease/ Traits----	❑
Arthritis---------------------	❑	Herpes / Fever Blisters------	❑	Sinus Problems-----------------	❑
Artificial Joints / Valves-	❑	High Blood Pressure---------	❑	Stroke----------------------------	❑
Asthma----------------------	❑	HIV+ / AIDS------------------	❑	Thyroid Problems--------------	❑
Cancer/ Chemotherapy--	❑	Kidney Problems/Disease--	❑	Tuberculosis (TB)--------------	❑
Congenital Heart Defect-	❑	Liver Disease------------------	❑	Ulcers----------------------------	❑
Diabetes---------------------	❑	Low Blood Pressure----------	❑	Venereal Disease--------------	❑
Difficulty Breathing-------	❑	Mitral Valve Prolapse--------	❑	Other not listed---------------	❑
Frequent Headaches------	❑	Osteoporosis-------------------	❑	Do you Smoke? ---------------	❑
Glaucoma-------------------	❑	Psychiatric Problems---------	❑	Do you Chew? -----------------	❑
Heart Attack----------------	❑	Radiation Treatment----------	❑	Do you drink a lot of Soda? -	❑

If YES, please explain: ______________________________

Are you ALLERGIC to any of the following?

If yes, what happened? ______________________________

Aspirin	❑	Latex	❑
Penicillin	❑	Sulfa	❑
Codeine	❑	Other__________________	❑

DENTAL HISTORY

Do you wear DENTURES? (partial or full)------------------------------------	❑
Are you UNHAPPY with your dentures?--------------------------------------	❑
Would you like to know about PERMANENT REPLACEMENTS?-----	❑
Are you APPREHENSIVE about dental treatment?-------------------------	❑
Have you had any PERIODONTAL (GUM) treatments?------------------	❑
Do your gums BLEED or feel TENDER or IRRITATED?---------------	❑
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)--------	❑
Are you UNHAPPY with the APPEARANCE of your teeth?-------------	❑
Are you aware of GRINDING or CLENCHING your teeth?------------	❑
Do you have HEADACHES, EARACHES, or NECK PAINS?----------	❑
Have you ever had pain/discomfort in your JAW JOINT? (TMJ/TMD)	❑
Have you worn BRACES on your teeth? (orthodontics)---------------------	❑
Do you have DISCOLORED teeth that bother you?----------------------	❑
Would you like your smile to LOOK BETTER or DIFFERENT?--------	❑
Do you REGULARLY use DENTAL FLOSS?------------------------------	❑
Do you use local ANESTHETIC for dental treatment?--------------------	❑

Reason for Today's Visit: ______________________________

Date of last Dental Care: ______________________________

Former Dentist: ______________________________

Date of last Dental X-rays: ______________________________

Whom can we thank for referring you to our office? ______________________________