Jane J. Chen D.D.S., PC
4715 Statesmen Drive, Suite E, Indianapolis, IN, 46250
Tel (317)578-9696 Fax (317)578-9797

PATIENT REGISTRATION FORM

TODAY'S DATE:_______________

PATIENT NAME: First________________Last__________________ MI_________ SSN ______-______-_______

E-mail:____Cell Phone: ( )___________-___________

Home Phone: ( )_____________-__________ Business Phone :( )____________-_____________

Mailing Address: Street___________________________________ Apt# _____City/State_______________Zip _______

Date of Birth: ___/____/_____ Sex: M F Employer_____________________Occupation: ______________

Whom may we thank for referring you? __________________

IN CASE OF EMERGENCY NOTIFY

___________________ ____________________________________ ______________ ______________

Name ***Address*** ***Home Phone*** ***Cell phone***

INSURANCE

Name of Insured ____________________ Relationship to patient___________________Birthdate ______________
SSN _______________ Date employed _________________Employer ___________________________________
Work phone________________Address of employer ______________________ City__________ State____ Zip_______
Insurance company _____________________________ Group number ______________
Insurance company address ______________________City_________ State___Zip____
Do you have any additional insurance? YES NO Name of Insurance ________________________________
Name of Insured ____________________ ____________ Relationship to patient______________________________

CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY

The undersigned hereby authorizes Dr. Chen and staff to perform any diagnostic aids deemed necessary to make a thorough diagnosis of my needs. I also authorize Dr. Chen and staff to perform any and all forms of dental treatment and therapy that may be indicated.

In consideration of treatment rendered the above- named Patient, I accept full financial responsibility. Insurance forms will be completed as a convenience to the Patient; however, payment is required at the time services are rendered, unless other arrangements are made in advance. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection cost, interest of 21% APR, court costs and reasonable attorney fees.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

I agree to be contacted by phone, email, fax or U.S. mail to convey information about appointments, lab test results, clarify medication dosages, or answer simple dental or insurance questions. You may leave a message on voice mail. You may disclose information to the following family members and/or non-family members.

	Phone Number	Relationship
Name		

Signature (patient, parent or legal guardian)___________________**Date** ________

Printed Name (patient, parent or legal guardian) ____________________________

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MEDICAL HISTORY

Patient's Name ____
Last **First** **Initial** **Date of Birth**

Physician's name, address and phone ____

Have you been seen by a physician in the past 2 years? YES NO If yes, why? ________________

Have you been hospitalized in the past 5 years? YES NO If yes, why? ________________

Have you ever had any operations or surgery? YES NO If yes, what condition? __________

Have you ever had prolonged or excessive bleeding that required special treatment? YES NO

Have you ever had any of the diseases or conditions listed below? (Please circle YES or NO)

Heart Problems…………….. YES NO
- mitral valve prolapse…....... YES NO
- heart murmur……………... YES NO
- artificial heart valve………. YES NO
- heart pacemaker…………... YES NO
- congenital heart lesions....... YES NO
- heart surgery…................... YES NO
- heart disease or attack…….. YES NO
- heart failure……………….. YES NO
- angina pectoris……………. YES NO
Artificial Joints/prosthesis….. YES NO
Rheumatic Fever……........... YES NO
High Blood Pressure……….. YES NO
Anemia……………………... YES NO
AIDS (HIV+) ……………...... YES NO
White Patch in Mouth.. YES NO
Stroke………………………. YES NO
Kidney Trouble…………….. YES NO
Ulcers……………………...... YES NO
Emphysema……………........ YES NO
Enlarged Lymph Node YES NO
Chronic Cough……………... YES NO
Tuberculosis (TB)………….. YES NO
Asthma……………………... YES NO

Sinus Trouble……………… YES NO
Allergies or Hives………… YES NO
Diabetes……………………. YES NO
Cancer or Tumor…………… YES NO
Radiation or Cobalt Tx……...YES NO
Chemotherapy……………… YES NO
Arthritis……………………..YES NO
Cortisone Medications……... YES NO
Glaucoma…………………... YES NO
Hepatitis…………………… YES NO
Yellow Jaundice…………….YES NO
Blood Transfusion………… YES NO
Alcohol or Drug Addiction… YES NO
Hemophilia…………………YES NO
Venereal Disease……………YES NO
Genital Herpes……………... YES NO
Cold Sores or Fever Blisters YES NO
Epilepsy or Seizures……….. YES NO
Fainting or Dizzy Spells…… YES NO
Nervous Disorders…………. YES NO
Psychiatric Treatment……… YES NO
Sickle Cell Disease………… YES NO
Thyroid Disease……………. YES NO
Hay Fever…………………... YES NO

List all prescription, over-the-counter and herb medications that you are taking and the reason you are taking them. ____

____

Do you have allergic or other unusual reactions to the following? YES NO If yes, circle:

Penicillin Aspirin Codeine Sulfa Dental Anesthetics Metals Latex

Other allergies (please list):____

Have you ever taken **Fosama**, **Zometa**, **Aredia**, or any other oral or intravenous treatment (Bisphosphonates) for bone tumors, excessive calcium in your blood, Osteoporosis? YES NO

If yes, please indicate the name of the drugs_______________________________________

Have you ever taken the appetite suppressant **phentermine** and **Phen-fen**? YES NO
Do you smoke, chew, use snuff or any other forms of tobacco? YES NO

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If yes, how many years and how many packs?____

Do you have family history of sleep-disorder-affected breathing? YES NO
Do you have frequent complaints of unrefreshing sleep and daytime sleepiness? YES NO
Do you have history of snoring, especially loud snoring? YES NO
Have you experienced sleep punctuated by episodes of choking, gasping, breath holding or snorting? YES NO

Do you have any other disease or condition not mentioned above? .... YES NO
If yes, list:
____

WOMEN ONLY:

Are you currently pregnant or breastfeeding? YES NO
If yes, what trimester are you in? (How many weeks pregnant are you?) ______________
Do you experience morning sickness? YES NO
Are you taking birth control pills or using other contraceptive medications? YES NO
Are you on hormone replacement therapy? YES NO

DENTAL HISTORY

Purpose of initial visit ____
Have you had regular visits? .... YES NO
How often: 3 months 4 months 6 months
How long since your last dental visit? ______________________________________
What was done at your last dental visit? ____________________________________
When was the last time your teeth were cleaned?______________________________
Previous dentist's name ____
Address: ____

CAVITY RISK ASSESSMENT:

Fluoride Exposure : YES NO If yes, please check: ○ drinking water ○ toothpaste ○ supplements ○ home fluoride gel/rinse ○ office fluoride application	Sugary or Starchy Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups) YES NO
Are your teeth sensitive to hot, cold, sweets or pressure? YES NO Does food or floss catch between your teeth? YES NO Is your mouth dry? YES NO	Cavities in last 2 years YES NO Teeth missing in past 2 years due to cavities YES NO

GENERAL QUESTIONS:

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Have you ever had any problems or complications with previous dental treatment? …… YES NO
Are any of your teeth loose, tipped, shifted or chipped? ……………………………… YES NO

How often do you brush your teeth? 1x/day 2x/day After each meal
What kind of toothbrushes do you use? Manual Electric
How often do you floss your teeth? 1x/day 2x/day After each meal

Have you lost any teeth/have any teeth been removed? ………………………………… YES NO
Why? ____
Have they been replaced? …………………………………………………… YES NO
Are you happy with the replacement? ……………………………………… YES NO
If no, explain ____

TMJ :
Do you clench or grind your teeth?..YES NO
Does your jaw click or pop?... YES NO
Have you experienced any pain or soreness in the muscles on your face or around your ear?...YES NO
Do you have frequent headaches, neck pain or shoulder pain? …………………………... YES NO

PERIODONTAL DISEASE:
Do your gums bleed when you brush and floss?.. YES NO
Do you feel your breath is offensive at times? …………………………………………..... YES NO
Have you had any periodontal treatments in the past?.. YES NO

SMILE ANALYSIS:

Are you interested in a free *Smile Design* Consultation?.. YES NO

To the best of my knowledge, all of the information provided on both sides of this registration form is correct.

____ ________________
Signature of Patient, Parent or Legal Guardian ***Date***