PATIENT REGISTRATION & HISTORY

Today's Date_____

Name_____ Soc.Sec. No._____
First Last

Address_____Age_____DOB_____

City_____ _State_____Zip_____ Home Phone_____

Email Address_____ Cell Phone_____

Single____ Married____ Divorced____ Separated____ Widowed____ Sex: M____ F____

Employed By_____Occupation_____ __How Long_____

Business Address_____ Work Phone_____

List **ALL** Dental Insurance Co._____ _____Policy No._____ Group No._____

Subscriber Name_____ DOB_____ Soc. Sec. No._____

Subscriber Employed by_____ Business Phone_____

Closest Relative not residing at above address_____

Whom may we thank for referring you?_____

Name of person financially responsible for account_____ Phone No._____

Family Physician_____

MEDICAL HISTORY

Has there been any change in general health? Yes No
Explain:_____

Are you under the care of a physician for any ongoing condition? Yes No
Explain:_____

Have you had any serious illness? Yes No
Explain:_____

Women: Are you pregnant? Yes No

Are you allergic to latex? Yes No

Are you allergic to any drugs? Yes No
What:_____

Have you ever had excessive bleeding? Yes No
Explain:_____

Are you on blood thinners? Yes No
(Coumadin, Plavix, Aspirin)

Are you on bone density medications? Yes No
(Aredia, Actonel, Zometa, Fosamax)

Have you ever had any of the following conditions?

Heart Surgery/ Attack	Yes	No	Hepatitis A,B,C	Yes	No
Congenital Heart Disease	Yes	No	AIDS/HIV	Yes	No
Heart Murmur	Yes	No	Stroke	Yes	No
Hi / Low Blood Pressure	Yes	No	Epilepsy	Yes	No
Anemia	Yes	No	Arthritis	Yes	No
Rheumatic Fever	Yes	No	Headaches (severe)	Yes	No
Diabetes	Yes	No	Tuberculosis (TB)	Yes	No
Tumors or Growths	Yes	No	Other	Yes	No
Major Joint Replacement	Yes	No			

When:_____

PLEASE SEE OTHER SIDE

PLEASE LIST CURRENT MEDICATIONS:

1._____ 3._____ 5._____

2._____ 4._____ 6._____

DENTAL HISTORY

Dental Complaint:_____

Date of last visit to dentist:_____

For what service:_____

Would you like a more attractive smile? Yes No

Do you wish your teeth were whiter? Yes No

Do you wish your teeth were straighter? Yes No

Do you have pain in the TMJ? Yes No

Does this joint ever pop or click? Yes No

If so, how often?_____

Do you have frequent headaches? Yes No

If so, how often?_____ Yes No

Have you ever received treatment for gum disease? Yes No

Explain:_____

Have you ever been told you have gum disease? Yes No

Do your gums bleed? Yes No

Any of your teeth sensitive to hot, cold, or sweets? Yes No

Does any part of your mouth hurt when chewing? Yes No

Explain:_____

Do you habitually grind or clench your teeth during the day or night? Yes No

Coming to the dentist is:

☐ An enjoyable experience Very stressful

☐ Unpleasant but tolerable Extremely terrifying (approaching death)

Do you normally have dental procedures done with nitrous oxide (laughing gas)? ___Yes ___No

The most difficult aspect of a dental procedure is:

☐ Injection Sensation of being numb

☐ Drill (noise) Being asked questions with objects in your mouth

☐ Opening mouth

FINANCIAL AGREEMENT

The undersigned does hereby undertake to pay all charges for the care and treatment provided by Dr. Caravas and his staff. If payment is not made within 60 days of treatment or as previously agreed upon in writing, then all sums due shall accrue interest at the rate of 12% per annum, and the undersigned will be responsible for all charges incurred in the collection of this account (including collection fees, attorney fees, court costs, and filing fees). We will be glad to file for any dental insurance you might have, however if payment is not received within 60 days, the undersigned will be required to pay the balance in full.

Patient_____ Date_____