Patient Registration

Information will be held in the strictest of confidence.

PATIENT INFORMATION

Patient Name	Date
Address	Social Security #
City, State, Zip	Birth date / Age
☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Minor	Cell Phone
Patient Employer / School	Work Phone / Ext.
Occupation	E-mail
Who is responsible for this account?	Relation:
How did you hear about our office?	

CONTACTS & INSURANCE

Your **SPOUSE**	**DENTAL INSURANCE**
Name	Subscriber's Name
Employer	Relation to patient
Cell Phone	Insurance Co.
IN CASE OF EMERGENCY, CONTACT	Is patient covered by additional dental insurance? ☐ Yes ☐ No
Name	Subscriber's Name
Relationship	Birth date / SS#
Phone	Insurance Co.

AUTHORIZATION

I understand and agree that I am financially responsible for all charges, whether or not paid by insurance. I also agree that I am responsible if my account is placed for collections, which includes but is not limited to interest charges, collection agency fees, and attorney's fees. I certify that the information that I have provided on both sides of this form is true and correct to the best of my knowledge. I agree to inform Dr. Telthorst of any changes in my health status or the above information.

SIGNATURE OF RESPONSIBLE PARTY ______________________ DATE ____________

(Please Complete Both Sides of This Form)

Dental & Medical History

REASON FOR THIS VISIT			
WHAT DO YOU EXPECT TO HAVE DONE TODAY?			
YOU USUALLY SEE A DENTIST:	☐ AT LEAST 2 VISITS A YEAR	☐ ABOUT ONCE EVERY 2 OR 3 YEARS	
	☐ AT LEAST ONCE A YEAR	☐ ONLY WHEN I HAVE A PROBLEM	
TELL US ABOUT YOUR LAST DENTIST:			
DATE OF LAST VISIT	WHAT WAS DONE THEN?		
WHY DID YOU LEAVE?			
WHAT DID YOU LIKE BEST?			
WHAT DID YOU LIKE LEAST?			
HOW OFTEN DO YOU BRUSH?	FLOSS?	DO YOUR GUMS EVER BLEED?	
ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH?			
IF YOU COULD CHANGE ANYTHING ABOUT YOUR TEETH, WHAT WOULD IT BE?		HEIGHT	WEIGHT

ARE YOU UNDER A PHYSICIAN'S CARE NOW?	☐YES ☐NO	IF YES:
EVER HAD A MAJOR OPERATION?	☐YES ☐NO	IF YES:
EVER HAD A JOINT REPLACEMENT?	☐YES ☐NO	IF YES:
EVER HAD A SERIOUS HEAD/NECK INJURY?	☐YES ☐NO	IF YES:
EVER HAD CANCER? LIST TYPE AND DATES.	☐YES ☐NO	IF YES:
DO YOU USE TOBACCO? DESCRIBE	☐YES ☐NO	IF YES:

WOMEN: ARE YOU...	☐ PREGNANT	☐ TRYING TO GET PREGNANT	☐ NURSING	☐ ON BIRTH CONTROL
ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?	☐ ASPRIN	☐ PENICILLIN	☐ CODEINE	☐ LOCAL ANESTHETICS
	☐ METAL	☐ LATEX	☐ SULFA DRUGS	☐ OTHER ALLERGY

PLEASE LIST ANY CURRENT MEDICATIONS:

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

☐ HEART DISEASE	☐ LIVER DISEASE	☐ HEARING IMPARED	☐ RADIATION TREATMENT
☐ HEART ATTACK	☐ HEPATITIS	☐ STOMACH DISEASE	☐ CHEMOTHERAPY
☐ HEART MURMUR	☐ BLOOD DISEASE	☐ STOMACH ULCERS	☐ DIABETES
☐ SCARLET FEVER	☐ EXCESSIVE BLEEDING	☐ ACID REFLUX	☐ ARTHRITIS
☐ ANGINA	☐ ANEMIA	☐ EPILEPSY/SEIZURES	☐ OSTEOPOROSIS
☐ MITRAL VALVE PROLAPSE	☐ LEUKEMIA	☐ ALZHEIMER'S DISEASE	☐ PARKINSON'S
☐ HEART PACEMAKER	☐ RENAL DIALYSIS	☐ AUTISM	☐ SHINGLES
☐ ARTIFICIAL HEART VALVE	☐ AIDS/HIV	☐ STROKE	☐ DRY MOUTH
☐ IRREGULAR HEARTBEAT	☐ LUNG DISEASE	☐ ADDICTION	☐ FREQUENT HEADACHES
☐ ARTIFICIAL JOINT	☐ ASTHMA	☐ PSYCHIATRIC CARE	☐ SLEEP APNEA
☐ HIGH BLOOD PRESSURE	☐ EMPHESEMA	☐ ANXIETY DISORDER	☐ NIGHT GUARD
☐ LOW BLOOD PRESSURE	☐ TUBERCULOSIS	☐ VERTIGO	☐ PAIN IN JAW JOINTS
	☐ SINUS TROUBLE	☐ TUMORS OR GROWTHS	☐ COLD SORES

PLEASE LIST ANY CONDITIONS NOT LISTED ABOVE:

(Please Complete Both Sides of This Form)