# Dental Registration and Health History

Patients Name_____ Social Security No._____

Birthdate_____ Age____ Sex____ Drivers License_____

Mailing Address_____

City_____ Zip_____

Home Phone _____

Cell Phone _____Email _____

Please ck (√ ) one: □ Single □ Married □ Divorced □ Widowed

Referred to our office by_____

Have you or any member of your family been seen by us before? □Yes □No

If yes, which family members_____

Emergency contact *other* than Spouse_____Phone (  ) _____ ____

Previous Dentist_____ City_____ Last seen_____

## Employment

□ I do not work, I am a full time student I attend: _____

Employer_____ Position_____

Employer's Address_____ City_____

Work Phone (  ) _____ Work Hours (shift) _____

## Spouse or Domestic Partner

Spouse's Name_____ Social Security No._____

Birthdate_____

Employer_____ Position _____

Employer's City _____ Phone (  ) _____

## Insurance

| | |
|---|---|
| Primary Insurance_____ | Second Insurance _____ |
| Group Number _____ or Local _____ | Group Number _____ or Local_____ |
| Policy holder's name_____ | Policy Holder's Name_____ |

# MEDICAL INFORMATION

☐ YES ☐ NO Are you having pain or discomfort at this time? Where?_____
☐ YES ☐ NO Have you been a patient in the hospital during the past two years?_____
☐ YES ☐ NO Have you seen a medical doctor during the past two years?
Physician's Name_____ Health Care# _____

☐ YES ☐ NO Are you currently taking any drugs or medications?

## Please list any drugs you are currently taking, the purpose they are taken

| DRUG | PURPOSE |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Indicate which of the following you have had or have at present. Check YES or NO to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Problems…… | ☐ YES | ☐ NO | Artificial Joints …… | ☐ YES | ☐ NO | Allergy to Latex…… | ☐ YES | ☐ NO |
| If yes, type_____ | | | Hard of Hearing……. | ☐ YES | ☐ NO | Emphysema…… | ☐ YES | ☐ NO |
| Ulcers…….. | ☐ YES | ☐ NO | Venereal Disease…… | ☐ YES | ☐ NO | Lupus…….. | ☐ YES | ☐ NO |
| Diabetes…….. | ☐ YES | ☐ NO | A.I.D.S/ HIV…… | ☐ YES | ☐ NO | | | |
| Heart Murmur…… | ☐ YES | ☐ NO | Thyroid Problems…… | ☐ YES | ☐ NO | Cold Sores/Fever Blisters…… | ☐ YES | ☐ NO |
| High Blood Pressure…… | ☐ YES | ☐ NO | Glaucoma…… | ☐ YES | ☐ NO | Blood Transfusion…… | ☐ YES | ☐ NO |
| Arteriosclerosis…… | ☐ YES | ☐ NO | Cancer…….. | ☐ YES | ☐ NO | Hemophilia…… | ☐ YES | ☐ NO |
| Mitral Valve Prolapse…… | ☐ YES | ☐ NO | If yes, type _____ | | | Anemia…….. | ☐ YES | ☐ NO |
| Artificial Heart Valve…… | ☐ YES | ☐ NO | Chronic Cough…… | ☐ YES | ☐ NO | Sickle Cell Disease…… | ☐ YES | ☐ NO |
| Heart Pacemaker…….. | ☐ YES | ☐ NO | Tuberculosis…… | ☐ YES | ☐ NO | Bruise Easily…….. | ☐ YES | ☐ NO |
| Heart Surgery…… | ☐ YES | ☐ NO | Asthma…….. | ☐ YES | ☐ NO | Liver Disease…… | ☐ YES | ☐ NO |
| Rheumatic Fever…… | ☐ YES | ☐ NO | Hay Fever…… | ☐ YES | ☐ NO | Kidney Disease…….. | ☐ YES | ☐ NO |
| Cortisone Medicine…… | ☐ YES | ☐ NO | Sinus Trouble…… | ☐ YES | ☐ NO | Epilepsy or Seizures…… | ☐ YES | ☐ NO |
| Drug Addiction…… | ☐ YES | ☐ NO | Radiation Therapy…… | ☐ YES | ☐ NO | Fainting or Dizzy Spells…….. | ☐ YES | ☐ NO |
| Stroke…….. | ☐ YES | ☐ NO | Chemotherapy…….. | ☐ YES | ☐ NO | Nervousness…….. | ☐ YES | ☐ NO |
| Tumors…… | ☐ YES | ☐ NO | Hepatitis B &C …… | ☐ YES | ☐ NO | Taken Biophosphonates…… | ☐ YES | ☐ NO |
| Parkinson's Disease…… | ☐ YES | ☐ NO | Eating Disorder…….. | ☐ YES | ☐ NO | Taken Fen Phen or Redux….. | ☐ YES | ☐ NO |

Do you have or have you had any disease, condition, or problem not listed? If Yes, please list

_____

Do you have or have you had an allergy or unusual reaction to the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Aspirin…….. | ☐ YES | ☐ NO | Valium…… | ☐ YES | ☐ NO | Codeine …… | ☐ YES | ☐ NO |
| Penicillin…… | ☐ YES | ☐ NO | Sulfa Drugs…… | ☐ YES | ☐ NO | Local Anesthetics…… | ☐ YES | ☐ NO |
| Percodan…… | ☐ YES | ☐ NO | Vicodin…… | ☐ YES | ☐ NO | Amoxicillian…… | ☐ YES | ☐ NO |
| Erythromycin……. | ☐ YES | ☐ NO | Other Antibiotics…… | ☐ YES | ☐ NO | Local Dental Anesthetic……. | ☐ YES | ☐ NO |
| Latex…… | ☐ YES | ☐ NO | | | | | | |

**FOR WOMEN**: Are you pregnant? ☐ YES ☐ NO Are you taking birth control pills? ☐ YES ☐ NO

If yes, expected delivery date? _____ Are you currently nursing? ☐ YES ☐ NO

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me, or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

Signature of Patient_____Date_____ Doctor's Signature_____

# Artmond Louie DDS, Inc.
## Patient Consent to Treatment

**NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT (HIPPA):**

We keep a record of your personal information and the dental care we provide to you. We use this information in order to provide you with patient care. We may use your phone number, e-mail or a post card to contact you regarding your treatment or appointment. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or obtain a summary of your chart (duplication fee depends on length of summary) by contacting our office Manager. Initial: _____

**DRUGS, MEDICATIONS AND ANESTHESIA:**

I understand that antibiotics, analgesics and other medications may cause adverse reactions, some of which are, but not limited to redness and swelling of tissues, pain, itching, vomiting and dizziness. I understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I understand that rarely, upon injection of a local anesthetic, I may have prolonged persistent anesthesia, numbness and/or irritation to the area of the injection. I understand that if I select to utilize Nitrous Oxide the possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock and cardiac arrest. FEMALES: I understand that while on birth control pills, if I am given antibiotics, I should use an alternative way of birth control. Antibiotics suppress the effects of birth control pills. Initial: _____

**INSURANCE BENEFITS AND PAYMENTS:**

If you are covered by insurance and bring the necessary information that enables us to confirm eligibility and benefits, we will be happy to bill them for your services. Upon request, an estimate will be given to me in writing, on the understanding that it is but a guideline of my treatment costs until final payment is received from your insurance company and your exact share of the bill is known. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than estimated and there is no guarantee of benefits from my insurance company to the dentist until a claim is received and processed for payment. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that the insurance company can deny payment on services rendered at any time and I will be responsible to pay the entire balance on my account. A $10.00 fee will be applied for late payments if I have a monthly statement.

Initial: _____

**CHANGE IN TREATMENT PLAN:**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth. The most common being, additional tooth surfaces or additional caries discovered while working on the planned treatment. Occasionally, we may need to do root canal therapy following routine restorative procedures due to the cavity being larger and deeper than anticipated. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results.

Initial: _____

**APPOINTMENTS:**

We ask that you be on time for your scheduled dental appointments and if it is necessary for you to change an appointment, that you give us at least 24 hours notice so that we are able to accommodate someone else in your reserved chair time. **Our office policy is to charge $50.00 for missed appointments.**

Initial: _____

**QUESTIONS:**

Questions you may have regarding your billing or treatment need to be brought to our attention immediately. It is in our policy to provide you with exceptional service, and would like to be informed if you feel that we are not doing an adequate job.

Print Name: _____

Signature: _____ Date_____