ARTISAN FAMILY DENTAL

PATIENT REGISTRATION

Please PRINT Clearly

Appointment Date ___/___/___

Patient Name _____ Sex ☐M ☐F Date of Birth ___/___/___

Address _____ City _____ Zip _____

Best Phone (____) _____-_____ ☐Cell ☐Home ☐Work ☐Other _____

Alt Phone (____) _____-_____ ☐Cell ☐Home ☐Work ☐Other _____

Email Address _____ Referring Medical Professional _____

How did you hear about us? ☐Friend ☐Co-worker ☐Yelp ☐Online Search ☐Google ☐Other _____

Visit our website? ☐Computer/laptop ☐Tablet ☐iPad ☐iPhone ☐Cell Phone ☐Other _____

Employer _____ City _____

Full Time Student? ☐No ☐Yes - Name of School _____

Spouse/Partner Name _____ Date of Birth ___/___/___

Best Phone (_____) _____-_____ Employer _____ City _____

Emergency Contact _____ Phone (____) _____-_____

☐Relative _____ ☐Friend ☐Other _____ City _____ State ____

Person Financially Responsible for Account _____

Phone (____) _____-_____ ☐Cell ☐Home ☐Work Relationship to Patient _____

Address _____ City _____ Zip _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ SS# _____-_____-_____ Date of Birth ___/___/___

Insurance Co _____ Phone (____) _____-_____ Group # _____

Insurance Company Address _____

Do you have Dual Coverage? ☐No ☐Yes - If yes, please complete the following

Insured's Name _____ SS# _____-_____-_____ Date of Birth ___/___/___

Insurance Co _____ Phone (____) _____-_____ Group # _____

Insurance Company Address _____

A $20.00 charge will billed monthly to all accounts owed over 90 days and a $40.00 fee will be charged for any returned check.

I have read this form, understand it and have answered the questions truthfully and to the best of my ability. I declare that I am financially responsible for all charges incurred during treatment. I understand that details regarding insurance coverage are based solely on information provided by the insurance company at the time of the inquiry. Any co-payment quoted is only an estimate.

X **Signature** _____ Date ___/___/___

In order to fulfill our obligation to protect the privacy of our patients, we adhere to the current Health Insurance and Accountability Act of 1966 (HIPPA). We may use or disclose your health information for treatment, to obtain payment for services we provide to you or for healthcare operations. At no other time will this information be used unless requested by you or required by law. Please feel free to request a copy of our privacy practices in its entirety or to discuss any questions you may have regarding our policy.

X **Signature** _____ Date ___/___/___

ARTISAN FAMILY DENTAL

HEALTH HISTORY

Patient Name _____
Date of last DENTAL exam _____/_____/_____
Date of last PHYSICAL exam _____/_____/_____

PLEASE CIRCLE THE APPROPRIATE ANSWER

YES NO Has there been a change in your health within the last year? How so? _____
YES NO Have you been hospitalized or had serious illness in the last three years?
If YES, why? _____
YES NO Are you being treated by a physician now? For what? _____
YES NO Do you have dental phobia?
YES NO Do you have difficulty getting numb?
YES NO Do you need an antibiotic before dental visits? Reason _____
YES NO Allergies to: drugs, foods, medications, latex, etc. Please list _____

HAVE YOU RECENTLY EXPERIENCED

YES NO Headaches
YES NO Seizures
YES NO Jaundice
YES NO Grinding teeth
YES NO Tiredness, falling asleep during day
YES NO Persistent cough, coughing up blood
YES NO Diarrhea, constipation, blood in stools
YES NO Difficulty swallowing
YES NO Fainting spells
YES NO Dry mouth
YES NO TMJ - Jaw Joint Problems
YES NO Shortness of breath
YES NO Recent weight loss, fever, night sweats
YES NO Bleeding problems, bruising easily
YES NO Sinus problems

DO YOU HAVE OR HAVE YOU HAD

YES NO HIV/AIDS
YES NO Skin diseases
YES NO Herpes
YES NO Thyroid, adrenal disease
YES NO Heart disease
YES NO Heart murmur
YES NO Stroke, hardening of arteries
YES NO Hepatitis, other liver disease
YES NO Stomach problems, ulcers
YES NO Psychiatric care
YES NO Chemotherapy
YES NO Blood transfusions
YES NO Contact lenses
YES NO Tumors, cancer
YES NO Anemia
YES NO Kidney, bladder disease
YES NO Diabetes - Type? _____
YES NO Heart attack, heart defects
YES NO Rheumatic fever
YES NO Abnormal blood pressure S_____ / D_____
YES NO Asthma, TB, emphysema, other lung diseases
YES NO Colitis
YES NO Radiation treatments
YES NO Prosthetic heart valve
YES NO Pacemaker
YES NO Artificial joint - When placed? _____

ARE YOU TAKING

YES NO Recreational drugs
YES NO Tobacco Form/type _____
YES NO Alcohol - How often? _____
YES NO Prescription medications, over-the-counter medications, (including aspirin or natural remedies)
Please list _____ _____
YES NO Are you currently taking or have you previously taken a bisphosphonate medication
Such as Actonel, Fosamax or Zometa? Please list _____

WOMEN ONLY

YES NO Are you or could you be pregnant or nursing? YES NO birth control pills?

ALL PATIENTS

YES NO Do you have or have you had any other diseases or medical problems NOT listed on this form?
Please list _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

X **Patient Signature** _____ Date ___/___/___

__ **Reviewed by** _____ Date ___/___/___