

# PATIENT REGISTRATION

# Cosmetic & Restorative Dentistry

P.O. Box 754 / 8360 W. Main St. - Marshall, Va 20116  
Phone 364-2400 Fax 364-3625 [www.smiledocs.org](http://www.smiledocs.org)

Please complete the following confidential information.

PATIENT REGISTRATION	PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT If different than information on left:
Patient's Name: _____	Name: _____
Prefers to be called: _____	Prefers to be called: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone #: _____ Fax: _____	Home Phone #: _____ Fax: _____
Work Phone #: _____ E-mail: _____	Work Phone #: _____ E-mail: _____
Cell Phone #: _____	Cell Phone #: _____
Birth Date: _____ Age: _____ Male / Female	Birth Date: _____ Age: _____ Male / Female
Social Security #: _____	Social Security #: _____
Occupation: _____	Occupation: _____
Employer: _____	Employer: _____

Is another member of your family or relative a patient at our office? Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

DENTAL INSURANCE INFORMATION	
Dental Insurance Co. Name: _____	Secondary Dental Insurance Name: _____
Group #: _____	Group #: _____
Employer Name: _____	Employer Name: _____
Insured Person's Name: _____	Insured Person's Name: _____
Birth Date: _____	Birth Date: _____
Relationship to Patient: _____	Relationship to Patient: _____
Insured Person's I.D. #: _____	Insured Person's I.D. #: _____
Insured Person's Social Security #: _____	Insured Person's Social Security #: _____
Insurance Co. Address: _____	Insurance Co. Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Insurance Co. Phone #: _____	Insurance Co. Phone #: _____

PLEASE TURN THIS PAGE OVER AND SIGN THE BACK. THANK YOU.

### CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated staff to **take x-rays, study models, photographs and other diagnostic aids** deemed appropriate by the doctor to make a **thorough diagnosis** of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment **mutually agreed upon by us**.
2. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. *I understand that I can ask for a complete recital of any possible complications.*
3. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that **payment is due at the time of service** unless other prior arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18%APR) may be added to my account.
4. I understand my confidential **treatment record** and **financial information** has been fully protected under the Privacy Rules governed by the Health Insurance Portability and Accountability Act (HIPAA). My personal health information will be shared exclusively for treatment, payment and/or healthcare operations with **specialists** or **insurance carriers** only, at my request and approval.

Signature: (parent or guardian) \_\_\_\_\_ Date: \_\_\_\_\_

**DENTAL HISTORY**

**The Leader in Cosmetic & Restorative Dentistry**

**Dr. Sam Aronhime [www.smiledocs.org](http://www.smiledocs.org)**

8360 W. Main St. - Marshall, Va 20116

Phone 364-2400 Fax 364-3625

Patient Name: \_\_\_\_\_

**What is the reason for your visit today?** \_\_\_\_\_

Are any of your teeth sensitive to *hot or cold*? **Yes No**

Are any of your teeth sensitive to *sweets*? **Yes No**

Any sensitivity to *biting or chewing pressure*? **Yes No**

Do you notice mouth odors? **Yes No**

Do you notice bad tastes? **Yes No**

Do your gums bleed or hurt? **Yes No**

If yes, how often? \_\_\_\_\_

Does food get caught between your teeth? **Yes No**

Is this a problem you want corrected? **Yes No**

Do you clench or grind your teeth? **Yes No**

Do you ever notice tired jaws or sore teeth? **Yes No**

Do you smoke or chew tobacco? **Yes No**

Are you currently missing any teeth? **Yes No**

Is this a problem you want corrected? **Yes No**

Have you ever had braces? **Yes No**

Have you ever had oral surgery? **Yes No**

Have you ever had periodontal surgery? **Yes No**

Do you wear a bite or "night" guard? **Yes No**

Any serious injury to the mouth or head? **Yes No**

Please describe: \_\_\_\_\_

Does your jaw click or pop? **Yes No**

Any pain in your jaw joint? **Yes No**

Frequent headaches? **Yes No**

Frequency and time of day of headaches: \_\_\_\_\_

Do you feel nervous about dental treatment? **Yes No**

If so, what are your concerns? \_\_\_\_\_

Date of: Last Dental Visit? \_\_\_\_\_ Last Cleaning? \_\_\_\_\_ Last x-rays? \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentists Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Your reason for leaving their office: \_\_\_\_\_

What did you *like* about your previous dental experiences? \_\_\_\_\_

What did you *dislike* about your previous dental experiences? \_\_\_\_\_

How often do you normally have dental examinations? Once per year Twice per year Three times per year More

How often would you prefer dental examinations? Once per year Twice per year Three times per year More

Would you like to discuss your options to enhance your smile? (i.e. whiter, straighter teeth.) **Yes No**

If yes, what are your goals & expectations? \_\_\_\_\_

Are you concerned about your silver-mercury fillings? **Yes No**

Is there anything else / other dental concerns we have not asked about that you want us to know? \_\_\_\_\_

How can we make each of your future visits more enjoyable? \_\_\_\_\_

Notes: \_\_\_\_\_

*PLEASE COMPLETE THE OTHER SIDE. THANK YOU.*

**MEDICAL HISTORY**

**The Leader in Cosmetic & Restorative Dentistry**

**Dr. Sam Aronhime [www.smiledocs.org](http://www.smiledocs.org)**

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Patient Name: \_\_\_\_\_

Have you been under the care of a medical doctor in the past two years? Yes No

If yes, please explain? \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone #: \_\_\_\_\_

List any medications or pills you take **now**, or have taken in the **last 6 months**. \_\_\_\_\_

List any medications or antibiotics you have had an adverse or **allergic reaction** to: \_\_\_\_\_

Indicate which of the following you have had, or have at present.

Heart (surgery, disease, attack)	Yes No	Chest pain	Yes No
Congenital heart disease	Yes No	Heart murmur	Yes No
High blood pressure	Yes No	Mitral valve prolapse	Yes No
Artificial heart valve	Yes No	Rheumatic fever	Yes No
Cortisone medicine	Yes No	Stroke	Yes No
Special / restricted diet	Yes No	Artificial joints	Yes No
Kidney trouble	Yes No	Ulcers	Yes No
Diabetes	Yes No	Thyroid problems	Yes No
Latex allergy	Yes No	Radiation therapy	Yes No
Chemotherapy	Yes No	Tumors removed	Yes No
Hepatitis A, B or C	Yes No	Veneral disease	Yes No
A.I.D.S.	Yes No	H.I.V. positive	Yes No
Blood transfusions	Yes No	Hemophilia	Yes No
Sickle cell disease	Yes No	Liver disease	Yes No
Yellow jaundice	Yes No	Epilepsy or seizures	Yes No
Fainting or dizzy spells	Yes No	Psychiatric care	Yes No

Do you have any other disease or condition not listed? Yes No If yes, please list. \_\_\_\_\_

**Women.** Are you: Pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of change in my health or medication.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

History Review

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_