WELCOME! AMADOR FAMILY DENTISTRY, PLLC
Patient Registration & Health Record (front & back)

In order to render the proper dental services, to you, would you please be kind enough to answer the following questions. Thank you for your cooperation.

_____
DATE

PATIENT'S NAME _____
LAST FIRST MIDDLE TITLE

_____
HOME ADDRESS CITY STATE ZIP CODE

_____ _____ _____ _____
HOME PHONE WORK PHONE CELL PHONE E-MAIL ADDRESS

_____ _____ _____ _____ _____
REFERRED BY SOCIAL SECURITY # DATE OF BIRTH MARITAL STATUS SEX

_____
EMPLOYER NAME ADDRESS CITY STATE ZIP CODE

_____ _____ _____
PERSON TO NOTIFY IN EMERGENCY PHONE # ALTERNATE #

PERSON RESPONSIBLE FOR ACCOUNT (If different from the above)

NAME:_____
LAST FIRST MIDDLE TITLE

_____ _____ _____ _____ _____ _____
HOME PHONE WORK PHONE SOCIAL SECURITY # DATE OF BIRTH MARITAL STATUS SEX

_____
EMPLOYER NAME ADDRESS CITY STATE ZIP CODE

DENTAL INSURANCE INFORMATION

_____ _____
EMPLOYER NAME OR PLAN NAME GROUP #

_____ _____
INSURANCE COMPANY NAME PHONE #

_____
CLAIMS ADDRESS CITY STATE ZIP CODE

_____ _____ _____ _____
SUBSCRIBER'S NAME DATE OF BIRTH I.D.# RELATIONSHIP TO PATIENT

MEDICAL HEALTH

NAME AND ADDRESS OF YOUR PRIMARY CARE PHYSICIAN: _____

GENERAL HEALTH (PLEASE CIRCLE): EXCELLENT GOOD FAIR POOR

HAVE YOU EVER BEEN TREATED FOR OR DO YOU CURRENTLY HAVE: (Please circle an answer for <u>each</u> question)

ABNORMAL BLEEDING	Y/N	DIABETES	Y/N	HEPATITIS B	Y/N	SHINGLES	Y/N
ALCOHOL ABUSE	Y/N	DIFFICULTY BREATHING	Y/N	HEPATITIS C	Y/N	SICKLE CELL DISEASE	Y/N
ALLERGIES	Y/N	DRUG ABUSE	Y/N	HIGH BLOOD PRESSURE	Y/N	SINUS PROBLEMS	Y/N
ANEMIA	Y/N	EMPHYSEMA	Y/N	HIV+/AIDS	Y/N	STROKE	Y/N
ANGINA PECTORIS	Y/N	EPILEPSY	Y/N	KIDNEY PROBLEMS	Y/N	THYROID PROBLEMS	Y/N
ARTHRITIS	Y/N	FAINTING SPELLS	Y/N	LIVER DISEASE	Y/N	TUBERCULOSIS	Y/N
ARTIFICAL BONES	Y/N	FEVER BLISTERS	Y/N	LOW BLOOD PRESSURE	Y/N	ULCERS	Y/N
ARTIFICAL HEART	Y/N	FREQUENT HEADACHES	Y/N	MITRAL VALVE	Y/N	VENEREAL DISEASE	Y/N
ASTHMA	Y/N	GLAUCOMA	Y/N	PACE MAKER	Y/N	YELLOW JAUNDICE	Y/N
BLOOD TRANSFUSION	Y/N	HAY FEVER	Y/N	PNEUMOCYST	Y/N	TOBACCO USE	Y/N
CANCER/CHEMO	Y/N	HEART ATTACK	Y/N	PSYCHIATRIC PROBLEMS	Y/N	ARE YOU PREGNANT?	Y/N
COLITIS	Y/N	HEART SURGERY	Y/N	RADIATION THERAPY	Y/N	# OF WEEKS	___
CONGENTIAL HEART	Y/N	HEMOPHILIA	Y/N	RHEUMATIC FEVER	Y/N		
COSMETIC SURGERY	Y/N	HEPATITIS A	Y/N	SEIZURES	Y/N	ARE YOU NURSING?	Y/N

ARE YOU TAKING ANY MEDICATIONS NOW? YES_____ NO_____
IF YES, PLEASE LIST WITH DOSAGES:

_____

ARE YOU ALLERGIC TO: PENICILLIN _____ CODEINE _____ LOCAL INJECTED ANESTHETICS _____
ANY OTHER MEDICATIONS: _____
HAVE YOU EVER HAD ANY SERIOUS ILLNESSES OR OPERATIONS: NO _____ YES_____
HAVE YOU BEEN HOSPITALIZED WITHIN 5 YEARS: NO_____ YES_____ REASON: _____
ANY ADDITIONAL INFORMATION ABOUT YOUR HEALTH WE SHOULD KNOW?

_____

MEDICAL REVIEW (FOR THE DOCTOR'S USE ONLY): Allergies: _____
Systemic Illnesses: _____ BP: / P:
Meds: _____ Hosp: _____

DENTAL HISTORY

DATE LAST SEEN BY A DENTIST: _____ REASON: _____

WHAT IS YOUR REASON FOR SEEING THE DENTIST TODAY? _____

DOES COLD, HEAT OR SWEETS CAUSE PAIN IN YOUR TEETH? WHERE AND DOES IS LINGER?

_____

WOULD YOU LIKE TO HAVE WHITER TEETH? _____

HAVE YOU EVER HAD ANY SERIOUS INJURY TO YOUR HEAD OR JAW? NO_____ YES_____
IF SO, PLEASE EXPLAIN: _____

DO YOU HAVE ANY SWELLING OR BUMPS IN YOUR MOUTH? NO_____ YES_____ WHERE?_____

HAVE YOU EVER HAD ANY PROBLEMS WITH AN EXTRACTION OF ANY OF YOUR TEETH? NO_____ YES_____
IF SO, PLEASE EXPLAIN _____

HAVE YOU EVER HAD ANY SPECIAL DENTAL WORK DONE (I.E. BRACES, PERIDONTAL SURGERY, WISDOM TEETH, ETC…)? NO_____ YES_____ WHAT AND WHEN?_____

WOULD YOU OR YOUR SPOUSE LIKE INFORMATION ON APPLIANCES TO PREVENT SNORING? _____

BY SIGNING THIS QUESTIONNAIRE, I CERTIFY THAT I HAVE ANSWERED EVERY QUESTION AND FILLED IN EVERY BLANK. I FURTHER CERTIFY THAT I HAVE ASKED FOR ASSISTANCE IN ANSWERING EVERY QUESTION I WAS UNSURE ABOUT OR DID NOT UNDERSTAND. TO THE BEST OF MY KNOWLEDGE, THE ANSWERS TO THESE QUESTIONS ARE COMPLETE AND ACCURATE. IN ADDITION, I AGREE TO INFORM THE DENTIST WHENEVER THERE IS A CHANGE IN MY HEALTH STATUS.

I AUTHORIZE THE DENTIST TO RELEASE HEALTH INFORMATION ABOUT ME AND INFORMATION ABOUT MY DENTAL TREATMENT TO OTHER HEALTH PROFESSIONALS AND TO INSURANCE COMPANIES. I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MYSELF OR MY DEPENDENTS IS MINE, DUE AND PAYABLE IN FULL AT THE TIME OF SERVICE UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN APPROVED BY THE DENTIST. I FURTHER UNDERSTAND THAT SHOULD MY ACCOUNT HAVE TO BE REFERRED TO AN ATTORNEY FOR COLLECTION, I AM RESPONSIBLE FOR ALL FEES AND COSTS INCURRED THEREIN. A ONE AND ONE HALF PERCENT PER MONTH SERVICE CHARGE WILL BE IMPOSED ON ACCOUNT BALANCES DUE OVER THIRTY DAYS. I ALSO AUTHORIZE ANY INSURANCE PAYMENTS MAY BE SENT TO THE ATTENDING DENTIST.

PERSON COMPLETING THIS FORM: _____ _____
SIGNATURE DATE

IF THIS FORM WAS NOT COMPLETED BY THE PATIENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

_____ _____
RELATIONSHIP TO PATIENT PRINTED NAME