Patient Registration

First Name: _____ Last Name: _____ Middle Initial:_____
Preferred Name:_____

Patient Information | Section One

Address: _____ Address 2: _____
City: _____State: _____ Zip: _____
Home Phone:_____Work Phone:_____
Cell Phone: _____ ☐ I would like to receive text correspondence

☐ I do not want to receive text correspondence

Birth Date:_____Sex: ☐Male ☐ Female
Social Security Number: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Partnered ☐Minor
Spouse's Name (if applicable): _____
Email Address: _____

☐ I would like to receive email correspondence ☐I DO NOT want to receive email correspondence

Patient Information | Section Two

Employment status: ☐Full Time ☐Part Time ☐Self Employed ☐Retired ☐Unemployed

Student Status: ☐Full time ☐ Part Time ☐N/A

Patient Employer or School: _____ Occupation:_____
Employer or School Address: _____
Employer or School Phone Number: _____
Whom may we thank for referring you to us? _____
Responsible Party (if someone other than the patient): _____
First Name: _____ Last Name: _____ Middle Initial:_____
Address: _____ Address 2: _____
City: _____State: _____ Zip: _____
Home Phone:_____Work Phone:_____Cell Phone:_____
Birthdate: _____ Social Security Number: _____
Relationship to Patient:_____

IN CASE OF EMERGENCY CONTACT (Please specify someone who does not live in your household)

Name: _____Relationship:_____
Home Phone:_____Work Phone:_____Cell Phone:_____

PATIENT NAME: _____

PATIENT INSURANCE INFORMATION

**Does the patient have dental insurance? ☐ Yes ☐ No

If yes, please fill out the information below.

Primary Insurance Information

Policy Holder's Name: _____

Address: _____ Address 2: _____

City: _____State: _____ Zip: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Patient ID # _____Group #: _____

Policyholder's Social Security #: _____ Policy Holder's Date of Birth: _____

Policyholder"s Employer: _____

Insurance Company: _____

Address: _____Providers Phone Number: _____

City: _____State: _____ Zip: _____

Secondary Insurance Information

Policy Holder's Name: _____

Address: _____ Address 2: _____

City: _____State: _____ Zip: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Patient ID # _____Group #: _____

Policyholder's Social Security #: _____ Policy Holder's Date of Birth: _____

Policyholder"s Employer: _____

Insurance Company: _____

Address: _____Providers Phone Number: _____

City: _____State: _____ Zip: _____

Assignment and Release

I certify that I, and/ or my dependent(s), have insurance coverage with _____

And assign directly to Annapolis Dental Suite all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dental office and its dentists may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining Insurance benefits or benefits payable for related services.

Whether dental insurance is involved or not involved, by signing below, I am acknowledging that I am responsible for any and all balances on this account.

Signature of Patient, Parent, Guardian or Personal Representative:

_____

Please print name of Patient Parent, Guardian or Personal Representative: _____

Relationship to Patient: _____ Date: _____

MEDICAL HISTORY FORM | PART ONE

Patient Name: _____

Birth Date: _____ Today's Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? ☐ Yes ☐ No If yes _____

Have you ever been hospitalized or had a major operation ☐ Yes ☐ No If yes _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Do you take, or have taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ☐ Yes ☐ No If yes _____

Are you on a special diet? ☐ Yes ☐ No If yes _____

Do you use tobacco? ☐ Yes ☐ No If yes _____

Please list all current medications, pills, or drugs you are currently taking: (use a separate sheet if necessary)

_____

_____

_____

_____

Women are you:

Pregnant/trying to get pregnant ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Taking Oral Contraceptives? ☐ Yes ☐ No

_____

Are you allergic to any of the following

☐ Aspiring ☐ Penicillin ☐ Codeine ☐ Barbiturates

☐ Iodine ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other Allergies not listed above? ☐ Yes ☐ No If yes _____

Do you use controlled substances? ☐ Yes ☐ No If yes _____

MEDICAL HISTORY FORM | PART TWO

Do you have, or have had, any of the following?

AIDS/HIV Positive	Yes	No	Fainting Spells/Dizziness	Yes	No	Tuberculosis	Yes	No
Alzheimer's Disease	Yes	No	Cough (persistent or bloody)	Yes	No	Tumors or Growths	Yes	No
Anaphylaxis	Yes	No	Frequent Diarrhea	Yes	No	Ulcers	Yes	No
Anemia	Yes	No	Frequent Headaches	Yes	No	Venereal Diseases	Yes	No
Angina	Yes	No	Low Blood Pressure	Yes	No	Swollen Neck Glands	Yes	No
Arthritis/Gout	Yes	No	Lung Disease	Yes	No	Radiation Treatments	Yes	No
Artificial Heart Valve	Yes	No	Mitral Valve Prolapse	Yes	No	Recent Weight Loss	Yes	No
Artificial Joint	Yes	No	Osteoporosis	Yes	No	Renal Dialysis	Yes	No
Asthma	Yes	No	Pain in Jaw Joint	Yes	No	Rheumatic Fever	Yes	No
Blood Disease	Yes	No	Parathyroid Disease	Yes	No	Rheumatism	Yes	No
Blood Transfusion	Yes	No	Psychiatric Care	Yes	No	Scarlet Fever	Yes	No
Breathing Problems	Yes	No	Special Diet	Yes	No	Shingles	Yes	No
Bruise Easily	Yes	No	Hemophilia	Yes	No	Sickle Cell Disease	Yes	No
Glaucoma	Yes	No	Hepatitis A	Yes	No	Sinus Trouble	Yes	No
Infective Endocarditis	Yes	No	Hepatitis B	Yes	No	Spina Bifida	Yes	No
Heart Attack/Failure	Yes	No	Hepatitis C	Yes	No	Stomach/Intestinal Disease	Yes	No
Heart Murmur	Yes	No	Herpes	Yes	No			
Heart Pacemaker	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Heart Trouble/Disease	Yes	No	High Cholesterol	Yes	No	Cancer	Yes	No
Nervous Problems	Yes	No	Hives or Rash	Yes	No	Chemotherapy	Yes	No
Cortisone Medicine	Yes	No	Hypoglycemia	Yes	No	Chest Pains	Yes	No
Diabetes	Yes	No	Irregular Heartbeat	Yes	No	Cold Sores	Yes	No
Chemical Dependency	Yes	No	Kidney Problems	Yes	No	Congenital Heart Disorder	Yes	No
Easily Winded	Yes	No	Leukemia	Yes	No			
Emphysema	Yes	No	Liver Disease	Yes	No	Convulsions	Yes	No
Epilepsy or Seizures	Yes	No	Swelling of Limbs	Yes	No	Back Problems	Yes	No
Abnormal Breathing	Yes	No	Thyroid Problems	Yes	No	Sleep Apnea	Yes	No
Excessive Thirst	Yes	No	Tonsillitis	Yes	No	Stent	Yes	No

Have you had any serious illness not listed YES NO If yes _____

Other Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____

Print Name: _____ Date: _____

DENTAL QUESTIONNAIRE

Reason for today's visit: _____

How do you feel about your smile? _____

Former Dentist: _____

City/State: _____ Phone Number: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

How often do you floss? _____ How often do you brush? _____

Do you gums bleed when you brush or floss?	☐ YES	☐ NO	☐ NOT SURE
Are you teeth sensitive to cold, hot, sweets or pressure?	☐ YES	☐ NO	☐ NOT SURE
Does food or floss catch between your teeth?	☐ YES	☐ NO	☐ NOT SURE
Do you experience dry mouth?	☐ YES	☐ NO	☐ NOT SURE
Have you had any periodontal (gum) treatment?	☐ YES	☐ NO	☐ NOT SURE
Have you ever had orthodontic (braces) treatment?	☐ YES	☐ NO	☐ NOT SURE
Have you had any problems associated with previous dental treatment?	☐ YES	☐ NO	☐ NOT SURE
Are you currently experiencing dental pain or discomfort?	☐ YES	☐ NO	☐ NOT SURE
Do you experience bad breath?	☐ YES	☐ NO	☐ NOT SURE
Do you have a burning sensation on the tongue?	☐ YES	☐ NO	☐ NOT SURE
Do you brux or grind your teeth?	☐ YES	☐ NO	☐ NOT SURE
Do you have any clicking or popping in your jaw?	☐ YES	☐ NO	☐ NOT SURE
Do you wear dentures or partials?	☐ YES	☐ NO	☐ NOT SURE
Do you participate in active recreational activities?	☐ YES	☐ NO	☐ NOT SURE
Have you ever had a serious injury to your head or mouth?	☐ YES	☐ NO	☐ NOT SURE
Do you bite your fingernails?	☐ YES	☐ NO	☐ NOT SURE
Do you have any loose teeth or broken fillings?	☐ YES	☐ NO	☐ NOT SURE
Are your gums swollen or tender?	☐ YES	☐ NO	☐ NOT SURE

MISSED APPOINTMENT / LATE CANCELLATION POLICY

We feel the doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the same courtesy. We understand that unforeseen circumstances do occur and ask that you advise the office if you will be unable to keep your scheduled appointment. As all appointments are reserved exclusively for you, please see our missed/cancelled appointment guidelines below.

Late arrival: When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive more than 10 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment.

For a 30-minute appointment with either your hygienist or your dentist:
If you are unable to keep your scheduled appointment, we require a 24-hour notice so that we may accommodate the needs of another patient. All patients will receive the opportunity to miss two scheduled appointments. A $25 fee will be charged to the patient account for any additional late-cancel/missed appointments.

For a 60-minute appointment (or more) appointment with either your hygienist or your dentist:
If you are unable to keep your scheduled appointment, we require a 48-hour notice so that we may accommodate the needs of another patient. A $50 fee will be charged to the patient account for any late-cancel/missed appointments.

Thank you for choosing Annapolis Dental Suite as your dental health provider.

Patient or Legal Guardian Name: _____

Patient or Legal Guardian Signature: _____
Date:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I, _____, have received a copy of this office's Notice of Privacy
(Print name)
Practices.

_____ _____
Signature Date

To the patient: If you wish for any information to be discussed with any person other than yourself please indicate below.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient