

PATIENT REGISTRATION



PATIENT INFORMATION

Patient Name _____ Preferred Name _____ Date _____

Address _____ City _____ State / Prov. _____ Zip / P.C. _____

E-Mail _____ Cell Phone _____ Home Phone _____

SS# / SIN _____ Birthdate _____

Sex: MALE FEMALE Gender You Identify As: _____

Check Appropriate Box: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

If College Student, F.T. / P.T., Name of School _____ City _____ State / Prov. _____

Patient's or Parent's / Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State / Prov. _____ Zip / P.C. _____

Spouse or Parent's / Guardian's Name _____

Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of an Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Phone _____ SS# / SIN _____ Employer _____

Is this Person Currently a Patient in Our Office? YES NO

INSURANCE INFORMATION

We can only file if we have updated information. Please provide the reception desk with name of insured, relationship to patient, and insurance card if available. We'll need SSN of the policy holder and or policy #.

This form gives us permission to contact the policy holder. If you do not have the information on hand, provide information here:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# / SIN _____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State / Prov. _____ Zip / P.C. _____

Insurance Company _____ Tel. Number _____

GRP # _____ Policy / I.D. # _____

Insurance Co. Address _____ City _____ State / Prov. _____ Zip / P.C. _____

By signing this form, you are stating that you have reviewed and agree to the financial and reservation policy provided to you by our office.

X _____
Signature of Patient or Parent Guardian If Minor

PATIENT'S DENTAL & MEDICAL HISTORY



Patient Name _____ Birth Date _____ 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 medication that you may be taking could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

DENTAL HISTORY

Reason for this visit: _____

When was your last dental visit? _____

What was done? _____

Previous Dentist (Name & Location) _____

Have you had a complete series of dental films (x-rays) taken? YES NO

If yes, when/where? _____

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

Is your drinking water fluoridated? YES NO

Do your gums bleed while brushing or flossing? YES NO

Are your teeth sensitive to hot or cold liquids/foods? YES NO

Are your teeth sensitive to sweet or sour liquids/foods? YES NO

Do you feel pain to any of your teeth? YES NO

Do you have any sores or lumps in or near your mouth? YES NO

Do you have any of these habits?

Thumb sucking Nail biting Cheek/lip biting Chewing on ice/foreign objects None

Have you noticed any loosening of your teeth? YES NO

Does food tend to become caught between your teeth? YES NO

Have you ever had periodontal treatment (gums)? YES NO

Have you ever had any difficult extractions in the past? YES NO

Have you ever had any prolonged bleeding following extractions? YES NO

Do/did your parents have dentures? YES NO

If you could change anything about your smile, what would you change? _____

Have you had any head, neck, or jaw injuries? YES NO If yes: _____

Have you ever experienced any of the following problems with your jaw?

Clicking Pain (Joint, Ear, Side of Face) Difficulty in opening or closing Difficulty in chewing None

Do you have frequent headaches? YES NO

Do you have any of these sleep patterns or conditions:

Sleep apnea Snoring Daytime Drowsiness Bed Wetting (for children) None

Do you clench or grind your teeth? YES NO

Have you ever worn a bite plate or other appliance? YES NO

MEDICAL HISTORY

Are you in good health? YES NO

Date of your last physical exam: _____

Are you now under the care of a physician? If yes, please list Physician's Name YES NO

If yes: _____

Have you ever been hospitalized or had a major operation? YES NO

If yes, list here: _____

Are you taking any medications, pills, or drugs? YES NO If yes, please fill out medication list separately.

Have you had any abnormal bleeding? YES NO

If yes, explain further: _____

Do you bruise easily? YES NO

Have you ever required a blood transfusion? YES NO

Have you had a recent weight loss? YES NO

Do you take, or have you taken Phen-Fen or Redux? YES NO

If yes, currently or how many years ago?: _____

***The following three questions are incredibly important for the dentist to know.**

*Do you take blood thinners, Warfarin, such as Coumadin, Xarelto? YES NO

*Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? YES NO

If yes, which one? _____ How often? _____ For how long? _____

*Have you ever been prescribed antibiotic pre-medication for dental treatment? YES NO

If yes, what medication? _____

Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? YES NO

Do you use tobacco? YES NO If yes, Cigarettes Cigar Chewing Tobacco Vape

Do you use marijuana? YES NO If yes, in what capacity? _____

Do you or have you used controlled substances? YES NO

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? YES NO

Are you pregnant? YES NO If yes, how many weeks? _____

Are you nursing? YES NO

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Acrylic

Metals (Nickel, Mercury)

Latex

Sulfa Drugs

Local Anesthetics like Novocaine

Barbiturates, Sedatives, or Sleeping Pill

Iodine

Other If yes: _____

Have you been fully vaccinated for COVID -19? YES NO

2800 Niles Road, Saint Joseph, Michigan 49085

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REVIEW OF SYSTEMS

Do you have or have you ever had the following medical conditions:

Aids or HIV Infection	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cortisone Medicine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hepatitis A	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Radiation Treatments	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Alzheimer's Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Renal Dialysis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Anaphylaxis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Drug Addiction	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hepatitis B or C	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Anemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Easily Winded	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Herpes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Rheumatism	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Angina	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Scarlett Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Arthritis/ Gout	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy or Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO	High Cholesterol	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Shingles	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Artificial Heart Valve	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Excessive Bleeding	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hives or Rash	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sickle Cell Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Excessive Thirst	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hypoglycemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sinus Trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Blood Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fainting Spells/ Dizziness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Irregular Heartbeat	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Spina Bifida	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Frequent Diarrhea	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Frequent Cough	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Kidney Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Breathing Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Liver Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Leukemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Stomach/ Intestinal Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Low Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Swelling of Limbs	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Genital Herpes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Lung Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Thyroid Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Mitral Valve Prolapse	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tonsillitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chemotherapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hay Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Osteoporosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chest Pains	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Attack / Failure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pain in Jaw Joints	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tumors or Growths	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cold Sores/ Fever Blisters	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Murmur	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Parathyroid Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ulcers	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Congenital Heart Disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Pacemaker	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Psychiatric Care	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Venereal Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Convulsions	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Trouble/ Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Artificial Joint	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hemophilia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Yellow Jaundice	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Back Problem/ Surgery	<input type="checkbox"/> YES	<input type="checkbox"/> NO	GERD/Acid Reflux	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

If yes to any of the above, please see next page to elaborate.

History of an eating disorder? YES NO If yes: _____

Do you have any disease, condition or problem not listed above? YES NO

If yes: _____

PHARMACY

What is the name of your local pharmacy? _____

COMMENTS

If needed, please use this space to elaborate any condition you answered yes to under Review of Systems. For example, "Breast cancer in 2005, now in remission."

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. I am consenting to all treatment provided by and agreed upon between myself and my dental providers.

X _____
Signature of Patient or Parent Guardian If Minor



PATIENT MEDICATION LIST

This is often the most important part of the medical history, please be as thorough as possible.

Name: _____ Today's Date: _____

In order to fill out the form, you need a list of all of your medicines or everything you take in front of you. Be sure you include medicine you take from all pharmacies that you use as well as any over-the-counter medicines, vitamins, herbs or minerals you may take. For every medicine (including ones you get without a prescription), vitamin or herb you take, please write down these things:

- Medication – The name of what you take (like Tylenol, Acetaminophen 500 mg)
- Dosage – How much you take of this (like 1 pill of 150 mg)
- Times/Day – How often you take the medication (like once, twice, three)
- Comments – Add any additional information such as why you take the medication

Medication	Dosage	Times/Day	Comments

Pharmacy: _____



HIPAA ACKNOWLEDGEMENT

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. A copy is provided in this packet.

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

Patient Name (Printed) _____

Signature _____ Date _____

TELEPHONE AND MAIL NOTIFICATION CONSENT

Due to our concern for your confidentiality, we are asking you sign this release which would allow us to contact you, the patient, about your upcoming appointments and/or dental treatment.

YES, I GIVE MY PERMISSION (PLEASE CHECK ALL THAT APPLY)

____ AT HOME / CELL ____ EMAIL

____ AT WORK ____ ANSWERING MACHINE / VOICEMAIL

____ NO, PLEASE DO NOT CONTACT ME IN ANY OF THE ABOVE WAYS OF COMMUNICATION

2800 Niles Road, Saint Joseph, MI 49085

Tel: 269-429-2511 | Fax: 269-429-5130 | info@smilesonniles.com | www.smilesonniles.com

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name (Printed) _____ Relationship _____

Name (Printed) _____ Relationship _____

Name (Printed) _____ Relationship _____

FOR OFFICE USE ONLY

We attempt to obtain written acknowledgment of receipt of our Notice of Policy Practices, but acknowledgment could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (*Please Specify*)



CONSENT TO RECEIVE ELECTRONIC COMMUNICATIONS

We know you are busy. Let us help by sending automated reminders and more. Our office is now able to send email and text messages to patients to confirm appointments, let you know of upcoming events, and provide additional communication notification! This is a great tool to utilize when a phone call isn't possible. However, we understand that some parties prefer to be called.

Please indicate if you would like to receive email and text message appointment confirmation and reminders, newsletters, marketing material, account updates and opportunities to provide feedback.

We may also use your information for direct and indirect marketing, including audience targeting.

You can withdraw your consent to receive electronic communications at any time by calling our office. Please note that you are responsible for providing our office with any updates to your email address and/or cell phone number.

Email Address _____

Cell Phone Number _____

YES, I would like to receive electronic communications

NO, please do not send me electronic communications

Printed Name _____ Date _____

Signature _____

Parent/Guardian _____