

Adult Registration Form (please fill in completely)

Name _____ Preferred name? _____ Date _____
Social Security Number _____ Birthdate ____/____/____
Address _____ City _____ State _____ Zip _____
Email _____ Home Phone _____ Cell Phone _____
Sex: M F Single ____ Married ____ Widowed ____
Employer _____ Position _____ Bus. Phone _____
Spouse's Name _____ Spouse's Social Security Number _____
Spouse's Employer _____ Bus. Phone _____ Cell Phone _____
Name of emergency contact _____ Phone _____
How did you learn about our office? _____

Health Information

When was your last dental appointment? _____

Are your teeth sensitive to: (please circle)
Heat Cold Sweets Biting Pressure
Do your gums bleed? Yes No
Are your gums swollen? Yes No
Unpleasant taste in your mouth? Yes No
Unpleasant odor in your mouth? Yes No
Do you have sleep apnea? Yes No
Do you snore when you sleep? Yes No
Do you grind your teeth? Yes No
Do you use any form of tobacco? Yes No

Do you have any general health problems? Yes No
If so, please specify _____

Have you had any surgeries? Yes No
If so, please specify _____

Are you currently under a physician's care? Yes No
If so, please specify _____

List current medications _____

Do you have:
Clicking of the jaw Pain (joints, ear, face)
Difficulty opening Difficulty closing
Difficulty chewing Chronic headaches

Do you have, or have you ever had: (please circle)

Do you have any dental fears? Yes No
If so, please specify _____

Abnormal Blood Pressure Arthritis Asthma
Chemical Dependency Cold sores
High Cholesterol Diabetes Epilepsy
Excessive/Prolonged Bleeding
Fainting Spells Glaucoma Hay fever
Heart Ailments Hepatitis HIV Positive
Jaundice Lung disease
Prosthetic implant Rheumatic fever Stroke

Are you pregnant? Yes No
If so, what month? _____

Allergy to any drugs, local anesthetic, latex, metals? Yes No
If so, please specify _____

I certify that the above information is correct. I am responsible for this account and understand that payment for all services is due upon treatment. There will be a service charge of 1.5% monthly – 18% annually on accounts past due.

Signature _____ Date _____

Insurance Information

Insurance Company Name & Address : _____

Insured Name & Address: _____

Insurance ID or SS #: _____ Group #: _____

Insured Employer: _____ Insured Birthdate: _____

Patient Name: _____ Patient Date of Birth: _____

Relationship to insured: ___self___ child___ spouse___ other___ Patient sex: ___M___ F

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. I authorize payment directly to Dr. O'Connell of the group insurance otherwise payable to me.

Signature: _____

Is patient covered by another dental insurance plan: ___Yes___ No, if yes, please continue

Insurance Company Name & Address: _____

Insured Name & Address: _____

Insured ID or SS#: _____ Group#: _____

Insured Employer: _____ Insured Birthdate: _____

HIPPA

We are required by law to maintain the privacy of your Protected Health Information. No information will be disclosed without written authorization, except as described in the Notice. Our office has posted the Notice of Privacy Practices for you to review. I have been informed of the above law.

Signature: _____

Record Release Form

Release records to: _____

Signature: _____ Date of Release: _____