Adult Registration Form (please fill in completely)

Name____Preferred name?_____________Date__________
Social Security Number____Birthdate____/____/_____
Address__________________________________City____________________State______Zip_______
Email ______________________________Home Phone______________Cell Phone________________
Okay to text appt. time/date?______________if so, cell phone carrier?__________________________
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:
Clicking of the jaw Pain (joints, ear, face)
Difficulty opening Difficulty closing
Difficulty chewing Chronic headaches

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

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

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, or have you ever had: (please circle)

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

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 Birthdate__________

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.Johnson 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/oral authorization, except as described in the Notice. Our office has posted the notice Notice of Privacy Practices for your to review. I have been informed of the above law.
Signature____

Record Release Form

Release records to____

Signature______________________________________Date__________