McDonogh Dental Associates

# PATIENT REGISTRATION CARD

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female Date:_____

PATIENT NAME: _____ SS#:_____ Birthdate: _____

Street Address: _____

City _____ State _____ Zip Code _____

PHONE: Home: _____ Work: _____

Pager: _____ Cell: _____

E-mail _____

Occupation _____ Employer name _____

Address _____

Spouse's Name and Work # _____

Children's Name(s) _____

REFERRED BY _____ PREVIOUS DENTIST _____

**PARTY RESPONSIBLE FOR PAYMENT:** (*Credit Bureau Reports May Be Obtained*)

Name _____ Phone _____

Home Address _____

_____ Relationship_____

Employer _____ Phone _____

**Signature**_____(*Patient, Parent or Guardian*)

This information is accurate to the best of my knowledge. I am aware that I am ultimately responsible for any services provided by McDonogh Dental Associates and that there is a service charge for any unpaid balance over 60 days.

**DENTAL INSURANCE:** *(IF APPLICABLE)*

Group/Employer Name _____ Group # _____

Insurance Company Name _____ Phone # _____

Address_____

Employee (Policy Holder)_____

Subscribe ID# _____ Employee Birthday _____

I hereby authorize McDonogh Dental Associates to affix my signature (or spouse's) on my behalf as of this date and to extend two years hereafter.

I authorize release of any information relating to this claim.

_____

Signature *(patient or parent if minor)* Date

I hereby authorize payment directly to the below named Dentist of the group insurance benefits otherwise payable to me.

_____

Signature (*Insured Person*)I Date

**DENTAL INSURANCE:** *(SECONDARY)*

Group/Employer Name _____ Group # _____

Insurance Company Name _____ Phone # _____

Address _____

Employee (Policy Holder) _____

Subscribe ID# _____ Employee Birthday _____

I hereby authorize McDonogh Dental Associates to affix my signature (or spouse's) on my behalf as of this date and to extend two years hereafter.

I authorize release of any information relating to this claim.

_____
Signature *(patient or parent if minor)* Date

I hereby authorize payment directly to the below named Dentist of the group insurance benefits otherwise payable to me.

_____
Signature (*Insured Person*)I Date

**EMERGENCY TREATMENT:** _____

_____

We respect your right to *choose* the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are *rarely* symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums- *until* it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission, we would like to explain the *choices* available to achieve long-term health and beauty for your existing natural teeth.

Please check ***all*** that apply:

- ☐ I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good and *last* for a long time.

  Spreading payments out over time may help me achieve the excellent result I desire.
- ☐ Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent result I desire.
- ☐ I *am* interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
- ☐ Although I am not interested in a plan for long-term dental health, I *do* desire an office who will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

_____ _____
Signature Date

**For Office Use**

McDonogh Dental Associates

# MEDICAL HISTORY

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female Date:_____

PATIENT NAME:_____ Birthdate:_____

## DENTAL HISTORY:

| | | | | | |
|---|---|---|---|---|---|
| Do you like the appearance of your teeth? | ☐Yes | ☐No | Do you experience bad breath? | ☐Yes | ☐No |
| Do you like the color of your teeth | ☐Yes | ☐No | Do you experience difficulty sleeping or loud disruptive snoring? | ☐Yes | ☐No |
| Are your teeth as straight as you would like them to be? | ☐Yes | ☐No | Have you had complications of past dental treatment? | ☐Yes | ☐No |
| Do you have a history bad TMJ disorder? | ☐Yes | ☐No | Have you seen any dental specialists in the past? | ☐Yes | ☐No |

Last Dental X-rays_____ Last Dental Exam_____

Do you have any concerns- (i.e. – fears/unusual pain or sensitivity relating to dental care)?_____

_____

If you could wave a magic wand and change something about your smile, what would it be?_____

_____

**PLEASE ANSWER THE FOLLOWING QUESTIONS WITH YES OR NO:**

*Have you ever been treated for or have had:*

| | | | | | |
|---|---|---|---|---|---|
| Heart Attack | ☐Yes | ☐No | Do you have a pacemaker? | ☐Yes | ☐No |
| Congenital Heart Disease | ☐Yes | ☐No | | | |
| Stroke | ☐Yes | ☐No | Have you had any blood transfusions? | ☐Yes | ☐No |
| Heart Surgery | ☐Yes | ☐No | Within the last ten years? | ☐Yes | ☐No |
| Irregular Heart Beat | ☐Yes | ☐No | | | |
| Ulcers (Stomach) | ☐Yes | ☐No | Have you ever taken: | | |
| Arthritis | ☐Yes | ☐No | Dilantin/anti-seizure medication | ☐Yes | ☐No |
| Mitral Valve Prolapse | ☐Yes | ☐No | Hormone replacement therapy | ☐Yes | ☐No |
| Tuberculosis | ☐Yes | ☐No | Calcium channel blockers/HBP | ☐Yes | ☐No |
| Sinus Trouble | ☐Yes | ☐No | Diet Suppressants (i.e. Phen/Phen) | ☐Yes | ☐No |
| Diabetes | ☐Yes | ☐No | Bisphosphonate(i.e. Fosamax/) | ☐Yes | ☐No |
| Glaucoma | ☐Yes | ☐No | Do you have a joint replacement? | ☐Yes | ☐No |
| Rheumatic Fever | ☐Yes | ☐No | Date of replacement_____ | | |
| Heart Murmur | ☐Yes | ☐No | or prosthetic heart valve? | ☐Yes | ☐No |
| Lung Disease | ☐Yes | ☐No | Date of replacement_____ | | |
| Asthma | ☐Yes | ☐No | Are you HIV positive? | ☐Yes | ☐No |
| Anemia | ☐Yes | ☐No | Are you subject to prolonged bleeding? | ☐Yes | ☐No |
| Cancer | ☐Yes | ☐No | Are you subject to fainting spells? | ☐Yes | ☐No |
| Hepatitis (Jaundice) | ☐Yes | ☐No | Do you use Tobacco(including smokeless Tobacco) products? | ☐Yes | ☐No |
| Type_____ | | | | | |
| Epilepsy | ☐Yes | ☐No | | | |
| Chemo and/or Radiation Treatment | ☐Yes | ☐No | | | |
| Substance Abuse | ☐Yes | ☐No | | | |
| Psychiatric Conditions | ☐Yes | ☐No | | | |
| Kidney Disease | ☐Yes | ☐No | | | |
| Abnormal Blood Pressure | ☐Yes | ☐No | | | |

**Are you allergic to:**

Codeine Yes ☐ No ☐
Penicillin Yes ☐ No ☐
Aspirin Yes ☐ No ☐
Other Meds/Allergies Yes ☐ No ☐
Please list:_____

Local Injected Anesthetics Yes ☐ No ☐
Latex Rubber Yes ☐ No ☐
Bananas, nuts kiwis Yes ☐ No ☐

**MEDICAL HEALTH:**

Name and phone number of Physicians and specialists:_____

_____

Do you have any condition that requires medication for dental treatment? *If yes, explain:*_____

_____

Have you had any serious illnesses or operations? *If yes, explain:*_____

_____

Is there any other information about your health that I should know?_____

_____

In the event of an emergency, is there an immediate relative as well as a non-household family member that we could contact?

_____

Phone:_____Relationship:_____

What medications are you taking? Please list: (include over the counter drugs and herbal supplements)_____

_____

_____

_____

(**FOR WOMEN:** Are you pregnant? ☐Yes ☐ No If yes, due date:_____Are you taking birth control? ☐ Yes ☐ No

I hereby consent to dental care including but not limited to cleanings, fillings, crown/bridges, full and/or partial dentures. I understand that during treatment, unforeseen conditions may arise which may necessitate procedures different from those discussed prior to treatment and any additional treatment which the dentist considers necessary. I consent to the use of **local anesthetics** and their potential risks. I have been given no assurances or guarantees as to outcome of the treatment. I realize that in spite of the possible complications, my proposed treatment is necessary and desired by me. I understand that it is vital that I give as **accurate and complete a medical and personal history** as possible, follow any and all instructions as directed any permit prescribed diagnostic procedures.

Signature:_____Date:_____

Patient/parent or guardian

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**MEDICAL HISTORY REVIEW: Hygienist initials, Patient signature, date**

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