Patient Registration Information (CONFIDENTIAL)

Name: ____
First Middle Last Preferred Name

Address: ____ ______________
City State Zip code Social Security #

Date of birth: ____________ Age: __________ Email Address: __________________________

☐ Home Phone: ________________ ☐ Cell: ________________ ☐ Work: ________________

**Mark Preferred Number

Referred by: ________________

Responsible Party Information (If under age 18 only)

Name: ____ ______________
First Middle Last Date of Birth

Address: ____ ______________
City State Zip code Social Security #

☐ Home Phone: ________________ ☐ Cell: ________________ ☐ Work: ________________

**Mark Preferred Number

Place of Employment: ________________________ Relationship to Patient: ________________

Insurance Information

Name of Insured: ____ ______________
First Middle Last Date of birth

Address of Insured: ____ ______________
City State Zip code Social Security #

Phone: __________ Place of Employment: ____________ Relationship to Patient: ____________

Insurance Company: ________________ Phone: ____________ Member ID: ______________

If you have dual insurance

Name of insured: ____ ______________
First Middle Last Date of birth

Address of Insured: ____ ______________
City State Zip code Social Security #

Phone: __________ Place of Employment: ____________ Relationship to Patient: ____________

Insurance Company: ________________ Phone: ____________ Member ID: ______________

Emergency Contact Information (Outside of immediate household)

Name: ____________________ Home Phone: ______________ Cell Phone: ____________

Financial Responsibility

We will gladly bill your insurance for you and estimate your share at the time of treatment. **Payment for your estimated portion is due at the time of service.** For your convenience we accept the following methods of payment (please check the option your prefer):

☐ Cash or Checks ☐ Mastercard or Visa ☐ Mothly payments (CARE CREDIT approval required)

I acknowledge that I am financially responsible for all charges and balances over 30 days may incur 1.5% monthly finance charge. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I understand that chronically missed and/or canceled appointments may result in a **$40 fee**. I authorize **Hidden Springs Family Dentistry** to bill my insurance company as well as release any information needed to do so and assign benefits to **Robert A. Darke, DDS, PC.**

Signature: ____ **Date:** ______________

Patient Dental History (CONFIDENTIAL)

Primary reason for your visit today? ______________________________

____

When was your last dental visit? ____________ Name of previous dentist: ______________________

Have your previous dental experiences been favorable? _____ If not, please explain: __________________

____

Reason for changing dentists: ______________________________

Have you experienced any of the following:	Yes	No		Yes	No
Sensitivity to hot or cold	☐	☐	Root canal treatment	☐	☐
Sensitivity to sweets or sour	☐	☐	Frequent headaches	☐	☐
Sensitivity to pressure/biting	☐	☐	Habitual grinding or clenching of teeth	☐	☐
Bleeding gums while brushing/flossing	☐	☐	Jaw joint pain	☐	☐
Frequently bite cheeks/lips	☐	☐	Clicking or popping of jaw	☐	☐
Sores or lumps in or around your mouth	☐	☐	Pain in ear or side of face	☐	☐
Gum recession	☐	☐	Crooked teeth	☐	☐
Periodontal (gum) treatment	☐	☐	Does food catch between your teeth	☐	☐
Cracked or broken teeth	☐	☐	Orthodontic treatment	☐	☐
Difficult extractions	☐	☐	Discolored teeth	☐	☐

Medical History

This information will help us in preventing serious medical complications. Please let us know if there is anything not listed, that you feel we should know about, in regards to your medical/dental health.

Name of Physician: ______________________ Date of last physical: ____________

Are you under medical treatment now? _____ If yes, describe: ______________________

Have you been hospitalized or had a serious illness in the last 3 years? ____ Explain: ______________

Do you smoke or use smokeless tobacco? _____ If yes, how often? ____________ How many years? _____

Please list any medications, including non-prescription medicine:

____

____

____

____

____

____

Allergies or reactions to:	Y	N
Local anesthetics	☐	☐
Codine	☐	☐
Aspirin	☐	☐
Latex	☐	☐
Sulfa drugs	☐	☐
Antibiotics	☐	☐

Please list: __________________

Other: __________________

Women: Are you pregnant?	☐	☐

Have you had, <u>at any time</u>, any of the following:

	Y	N		Y	N
Aids/HIV	☐	☐	Heart Murmur	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐
Angina/Chest pain	☐	☐	Herpes	☐	☐
Artificial joint/Implant	☐	☐	High Blood Pressure	☐	☐
Asthma/resp. problems	☐	☐	Jaundice	☐	☐
Bleeding problems	☐	☐	Kidney Disease	☐	☐
Cancer	☐	☐	Liver Disease	☐	☐
Chemotherapy	☐	☐	Pacemaker	☐	☐
Diabetes	☐	☐	Psychiatric care	☐	☐
Dizziness/Fainting	☐	☐	Sleep Apnea	☐	☐
Easily Winded	☐	☐	Stomach issues/ulcers	☐	☐
Epilepsy/Seizures	☐	☐	Stroke	☐	☐
Emphysema/COPD	☐	☐	Thyroid problems	☐	☐
Glaucoma/Cataracts	☐	☐	Tuberculosis	☐	☐
Heart Attack	☐	☐	Use of CPAP	☐	☐
Heart Disease	☐	☐	Other ____________		

I have read and understand the above information and have answered truthfully to the best of my knowledge. I understand that providing incorrect information may be dangerous to my medical/dental health.

Signature: ______________________________ **Date:** ______________