NORD Dental Center PC

New Patient Registration

Today's Date _____

Patient Information (CONFIDENTIAL)

Name _____ Preferred Name _____

Birthdate _____ SS#_____

Address _____ City _____ State____ Zip code _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____

Emergency contact/Phone Number _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Other

Whom may we thank for referring you? _____

Responsible Party

Name of Person Responsible for this Account_____

Contact Phone Number_____ Relationship to Patient_____

Is the person responsible currently a patient in our office ☐ Yes ☐ No

Dental Insurance Information

Name of Insured _____ Name of Employer _____

Birthdate of Insured _____ Relationship to Patient _____

Insurance Company_____ Group# _____ ID#_____

Insurance Co. Phone Number _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE ☐ Yes ☐ No If yes, complete the following

Name of Insured _____ Name of Employer _____

Birthdate of Insured _____ Relationship to Patient _____

Insurance Company _____ Group# _____ ID# _____

Insurance Co. Phone Number _____

I acknowledge that all money is due the day of service. If I have dental insurance then only my portion will be due at the time of service. I understand that payment plans are not offered, however Care Credit is available (apply within). I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents and that any unpaid balance after insurance will be subject to collections.

_____

Signature of patient (or parent/guardian if minor)

Patient's Name: _____

NORD Dental Center PC

Medical History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of the information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable law. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

MEDICAL HISTORY

Primary Physician's Name | Address | Zip code | Phone Number

_____ (____) _____

Has there been any change in your general health within the past year?..... Yes/No

When was your last visit to a physician? _____ N/A □

What was the reason for the visit? _____

Are you currently under the care of a medical physician for any reason other than regular physicals?..... Yes/No

If so, what is the condition being treated? _____

Have you had a serious illness, injury or been hospitalized in the past 5 years? ..... Yes/No

If yes, what was being treated? _____

Do you have any physical limitations?..... Yes/No

Describe _____

Please list any medications(s) you are currently taking as well as non-prescription medicine:

_____

_____

Has a physician or other dentist recommended that you take antibiotics prior to your dental treatment?..... Yes/No
(Please see section below for possible reasons)

If yes, Name of physician: _____ Phone: _____

Recommended antibiotic and dosage: _____

Yes	No	
□	□	Have you had an **orthopedic total joint (hip, knee, shoulder, elbow, finger) replacement?**
		If yes, date of surgery: _____ Did you have any complications? _____
□	□	**Artificial (prosthetic) heart valve**
□	□	**Previous infective endocarditis**
□	□	Damaged valves in transplanted heart
□	□	Congenital heart disease
□	□	Unrepaired, cyanotic CHD
□	□	Repaired CHD (completely) in last 6 months
□	□	Repaired CHD with residual defects

□	□	Do you use tobacco (smoking, snuff, chew)?	
		If so, how interested are you in stopping?	
		Circle one: VERY/ SOMEWHAT/ NOT INTERESTED	
□	□	Do you use use controlled substances?	
□	□	Do you drink alcoholic beverages?	
		If yes, how much do you typically drink in a week? _____	

Yes	No	
□	□	Do you Snore?
□	□	Do you feel fatigued during the day?
□	□	Do you wake up feeling like you haven't slept?
□	□	Have you been told you stop breathing at night?
□	□	Do you gasp for air or choke while sleeping?

Do you have or have had any of the following?

Yes No

- ☐ ☐ Cardiovascular Disease
- ☐ ☐ Angina
- ☐ ☐ Arteriosclerosis
- ☐ ☐ Congestive Heart Failure
- ☐ ☐ Damaged Heart Valves
- ☐ ☐ Heart Attack
- ☐ ☐ Heart Murmur
- ☐ ☐ Low Blood Pressure
- ☐ ☐ High Blood Pressure
- ☐ ☐ Other Congenital Heart Defects
- ☐ ☐ Mitral Valve Prolapse (MVP)
- ☐ ☐ Pacemaker
- ☐ ☐ Rheumatic Heart Disease
- ☐ ☐ Abnormal Bleeding
- ☐ ☐ Anemia
- ☐ ☐ Blood Transfusion
  If yes, date: _____
- ☐ ☐ Arthritis
- ☐ ☐ Osteoporosis
- ☐ ☐ Persistent Swollen Glands in Neck
- ☐ ☐ Autoimmune Disease
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Asthma
- ☐ ☐ Emphysema or COPD
- ☐ ☐ Sinus Trouble

Yes No

- ☐ ☐ Cancer
- ☐ ☐ Chemotherapy
- ☐ ☐ Radiation Treatment
- ☐ ☐ Diabetes Type I or II
- ☐ ☐ Thyroid Problems
- ☐ ☐ Eating disorder
- ☐ ☐ Gastrointestinal Disease
- ☐ ☐ G.E. Reflux/Persistent Heartburn
- ☐ ☐ Ulcers
- ☐ ☐ Hepatitis
- ☐ ☐ Jaundice
- ☐ ☐ Liver Disease
- ☐ ☐ Bladder Problems
- ☐ ☐ Kidney Disease
- ☐ ☐ AIDS or HIV Infection
- ☐ ☐ Epilepsy
- ☐ ☐ Fainting Spells
- ☐ ☐ Seizure
- ☐ ☐ Stroke
- ☐ ☐ Organ Transplant
  Specify: _____
- ☐ ☐ Neurological Disorder
  If yes, specify: _____
- ☐ ☐ Emotional/Mental Health Disorder
  Specify: _____
- ☐ ☐ Sexually Transmitted Disease
  Specify: _____

Allergies. Are you allergic to or have you had an allergic reaction to:

Yes No

- ☐ ☐ Local Anesthetic
- ☐ ☐ Aspirin

Antibiotics (bolded)

- ☐ ☐ **Penicillin**
- ☐ ☐ **Amoxicillin**
- ☐ ☐ **Clindamycin**
- ☐ ☐ **Tetracycline**
- ☐ ☐ **Erythromycin**
- ☐ ☐ **Other Antibiotics**: specify_____
  _____
- ☐ ☐ Sedatives
- ☐ ☐ Sulfa Drugs
- ☐ ☐ Codeine
- ☐ ☐ Metals
- ☐ ☐ Latex
- ☐ ☐ Iodine
- ☐ ☐ Hay Fever/Seasonal
- ☐ ☐ Milk Protein Casein LGE
- ☐ ☐ Animals
- ☐ ☐ Food
- ☐ ☐ Other Allergies, specify _____
  _____
  _____

Are you taking or scheduled to begin taking an Antiresorptive agent (like Fosomax, Actonel, Atelvia, Boniva, Reclast, Prolia) for Osteoporosis or Paget's Disease?.....Yes/No

Since 2001, were you treated or are you presently scheduled to begin treatment with an Antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, Multiple Myeloma or Metastatic Cancer?.....Yes/No

Date treatment began: _____

Do you have any of the following diseases or problems?

Yes No

- ☐ ☐ Active Tuberculosis
- ☐ ☐ Been exposed to anyone with Tuberculosis
- ☐ ☐ Persistent cough greater than a 3 week duration
- ☐ ☐ Cough that produces blood

WOMEN ONLY Are you:

Pregnant?..... Yes/No
Number of week's _____
Taking birth control pills or hormone replacements?..... Yes/No
Nursing?..... Yes/No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

*X*_____

Signature of patient (or parent/guardian if minor) *Date*

NORD Dental Center PC

Patient's Name: _____

Dental History

Yes	No	
☐	☐	Do your gums bleed when you brush or floss?
☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?
☐	☐	Is your mouth dry?
☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	Have you had any orthodontic (braces) treatment?
☐	☐	Have you had any problems associated with previous dental treatment?
☐	☐	Is your home water supply fluoridated?
☐	☐	Do you drink bottled water or filtered water? If yes, how often? **Circle one**: DAILY/WEEKLY/OCCASIONALLY
☐	☐	Are you currently experiencing dental pain or discomfort?

Yes	No	
☐	☐	Do you have earaches or neck pains?
☐	☐	Do you have any clicking, popping or discomfort in the jaw?
☐	☐	Do you grind your teeth?
☐	☐	Do you have sores or ulcers in your mouth?
☐	☐	Do you wear dentures or partials?
☐	☐	Do you participate in active recreational activities? If yes, would you be interested in a custom mouth guard? Yes/No
☐	☐	Have you ever had a serious injury to your head or mouth?

Date of your last dental exam: _____
What was done at that time? _____
Date of last dental x-rays: _____

Is there anything about your smile that you would like to change?

What is the reason for your dental visit today?