



PATIENT REGISTRATION

Patient's Name: _____ Today's date: _____

If a minor, parents' names _____

Home Address _____ Apt # : _____

City _____ State _____ Zip _____ - _____

Home phone: (_____) _____ Cell phone: (_____) _____

E-mail Address: _____

Marital status: _____ Single _____ Married _____ Divorced _____ Widowed _____ Separated

Sex: _____ M _____ F Birth Date: _____ / _____ / _____ Social Security # _____ - _____ - _____
MM DD YYYY

Occupation: _____ Business phone: (_____) _____ Ext: _____

Employer & Address: _____

Spouse's name: _____ Employer : _____

Business phone: (_____) _____ Ext: _____

Please circle where you prefer to receive calls? Home Work Cell

When is the best time to reach you? Time: _____ AM/PM Days: _____

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

Whom may we thank for referring you to our office? _____

Please circle your method of payment: Cash Bank Card Insurance

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN YOURSELF

Name: _____ Relationship : _____

Home Phone: _____ Social Security # _____ - _____ - _____

Employer: _____ Work Phone # : _____ Ext: _____

Driver's License # : _____

Billing Address: _____

Street or P.O.Box

City

State

Zip

PRIMARY INSURANCE

Employed person _____ Employed person's birth date: ____/____/____
MM DD YYYY

Insurance company: _____ Insurance company phone # (_____) _____

Insurance's billing address _____

Employer's name _____

Employee's Social Security # _____ - _____ - _____ Group # _____

SECONDARY INSURANCE

Employed person _____ Employed person's birth date: ____/____/____
MM DD YYYY

Insurance company: _____ Insurance company phone # (_____) _____

Insurance billing address: _____

Employer's name _____

Employee's Social Security # _____ - _____ - _____ Group # _____

Patient Dental History

Name of Previous Dentist and Location: _____ Date of Last Dental Exam: _____

	YES	NO		YES	NO
1. Do your gums bleed while brushing or flossing?.....	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?...	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw? Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you wear dentures or partials?..... If yes, date of placement ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing.....	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>	17. Have you ever been numbed to clean your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
			18. Do you have a limited opening?.....	<input type="checkbox"/>	<input type="checkbox"/>

Visit

Why have you come to the dentist today? _____

						YES	NO
1. Are you currently in pain?						<input type="checkbox"/>	<input type="checkbox"/>
2. Do you require antibiotics before treatment?.....						<input type="checkbox"/>	<input type="checkbox"/>
3. Have you experienced problems associated with any previous dental work?.....						<input type="checkbox"/>	<input type="checkbox"/>
4. Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?						<input type="checkbox"/>	<input type="checkbox"/>
5. Your current dental health is:	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor				
6. Do you floss daily? <input type="checkbox"/> Yes	<input type="checkbox"/> No	Brush twice Daily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
7. Type of bristles on your toothbrush?	<input type="checkbox"/> Hard	<input type="checkbox"/> Medium	<input type="checkbox"/> Soft				
8. How long do you use a toothbrush before replacing it? _____						<input type="checkbox"/>	<input type="checkbox"/>
9. Do you use anything in addition to your brush and floss?.....						<input type="checkbox"/>	<input type="checkbox"/>
If yes, what? _____							
10. Would you like fresher breath? <input type="checkbox"/> Yes <input type="checkbox"/> No			Whiter teeth?			<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had periodontal disease?.....						<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have mobility in your teeth?.....						<input type="checkbox"/>	<input type="checkbox"/>
13. Do you still have wisdom teeth?.....						<input type="checkbox"/>	<input type="checkbox"/>
14. Why did you leave previous dentist? _____							
15. What did you like the most and the least about any dentist you have seen? _____							

Patient Medical History

Physician: _____ Office Phone: _____ Date of Last Medical Exam: _____

						YES	NO
1. Are you under any medical treatment now?						<input type="checkbox"/>	<input type="checkbox"/>
2. Ever been hospitalized for any surgical operation or serious illness with in the past 5 years?						<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____							

3. Are you taking any medications(s) including non-prescription medicine?						<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any of the following:							
Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Thyroid Medicine				
Y N Antibiotics	Y N Blood Pressure Meds	Y N Nitroglycerine	Y N Tranquilizers				
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs					
Y N Aspirin	Y N Digitalis/Heart Meds	Y N Steroids/Cortisone					

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? Y N

If yes, please list each one: _____

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ Insurance Company and I assign directly to Harmony Dental all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and that I am also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize Harmony Dental to release all information necessary to secure this payment of benefits. I authorize the use of this signature on all my insurance sub-missions, whether manual or electronic.

X _____
Signature Date