Putnam Family Dental

Patient Registration Information
CONFIDENTIAL

Name: _____ Date: _____
First Middle Last

WELCOME TO OUR PRACTICE!
Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance-we will be happy to help!

Patient Information

Home Address_____City_____State_____Zip_____

Birthdate_____ SSN_____ Home Phone_____

E-Mail_____ Cell Phone_____

Do you prefer to receive calls at: Work Home Cell Either

Are you: Minor Single Married Divorced Widowed Separated

Your or your parent/guardian's employer _____Occupation_____

Business Address _____City _____State_____Zip_____

Spouse or parent/guardian's name _____Employer_____Work Phone _____

If you are a student, name of school/college _____City_____State_____

☐

Whom may we thank for referring you? _____

Person to contact in a case of an emergency? _____

Responsible Party

Name of person responsible for this account_____Relationship_____

Address: _____City_____State_____Zip_____

Home Phone:_____Cell Phone: _____SS # _____

Driver's License #_____Birthdate_____Financial Institution_____

Employer_____Work Phone_____

Is this person currently a patient in our office? Yes_____ No_____

Dental Insurance Information

Name of Insured_____
Relationship to patient_____D/O/B_____SS#_____Date Employed_____
Address of Employer_____City_____State_____Zip_____
Insurance Company_____Ins. Company Address_____
Group#_____ID#_____How much is your deductible?_____
How much have you used?_____Annual Maximum Benefit_____

Do you have additional Dental Insurance?_____

ALL ANSWERS ARE STRICTLY CONFIDENTIAL

TO THE PATIENT: Your answers are important for the protection of your health and that of the staff of *Putnam Family Dental*. Please answer the following questions about your health for our files. Your answers are important for your treatment.

Medical Conditions

YES NO Hepatitis-Type **A**,**B**,**C** or **Delta**
YES NO Diabetes: insulin dependent or diet controlled
YES NO Patient in the hospital in the past 2 years
YES NO Artificial Joint Replacement
YES NO Kidney Disease/Transplant/Dialysis
YES NO Cancer: Type:_____
YES NO Chemotherapy/Radiation Therapy Date:_____
YES NO **Are you Allergic To Any Medicines?**
If YES, Please List Below:
_____
_____
YES NO High Blood Pressure
YES NO Venereal Disease-Date_____
YES NO Do you use smokeless tobacco?
If YES, how frequently? _____
YES NO Are you undergoing Psychiatric Treatment?
YES NO Abnormal Bleeding
YES NO Are you Pregnant or Nursing?
If YES Due Date: _____

YES NO Low Blood Pressure
YES NO Asthma
YES NO Tuberculosis
YES NO Seizures
YES NO Stroke: Date:_____
YES NO Hyperthyroidism
YES NO Slow-Healing or Mouth Sores?

YES NO Do you smoke?
If YES, how much?_____
YES NO Kidney Disease
YES NO Blood Disease? What Kind_____
YES NO Tested positive for HIV
If YES, Date:_____
YES NO Malignant Hyperthermia
YES NO Do you use Alcohol
If YES, how frequently?_____
YES NO Recurrent Illness?
YES NO Have you ever taken Fen-Phen for weight loss?

YES NO Are you taking birth control (*NOTE: in combination with antibiotics your birth control pills may become **ineffective**).
YES NO Are you taking Viagra(*Note: in the event of a heart attack, administration of nitroglycerin will be **FATAL!)**
YES NO **Are you taking any medications?**
If yes, for what purpose(s)? Please list below:

Name Of Drug	Purpose

Are you taking any of these Medications? Please Circle

Antacids
Tagamet (cimetidine) or Prilosec
Dilantin or Tegretol
Barbiturates
St. John's Wart or Kava-Kava
Cardizem (diltiazem) or Calan, Isoptin (verapamil)
Serzone (nefazodone)
Diflucan (fluconazole) or Sporonox (itraconazole)
Biaxin (clarithromycin)

Heart Problems

YES NO Murmurs
YES NO Bypass Surgery
YES NO Heart Attack-Date:_____
YES NO Pacemaker
YES NO Angina Pectoris
YES NO Rheumatic Fever
YES NO Artificial Valves
YES NO Mitral Valve Prolapse
YES NO Heart Stent? When placed?
YES NO Abnormal Heart or
YES NO Previous Bacterial Endocarditis

Doctors Comments

_____
_____
_____
_____
_____
_____
_____
_____
_____
Drs.Signature_____
Date: _____

Are You Allergic To Any Of The Following? Please Circle

Local Anesthetics
Sulfa Drugs
Latex Allergy
Other :_____

Barbiturates
Sedatives
Codeine/Valium
Aspirin, Ibuprofen, Tylenol

Iodine
Penicillin or other
Antibiotics_____
_____

Circle any of the following if you have had or have at present

Scarlet Fever	Ulcers	Emphysema	Cough	Epilepsy	Hemophilia	Thyroid Disease
Liver Disease	Alcoholism	Drug Addiction	Pain in Jaw	Glaucoma	Birth Defects	Anemia
Sinus Trouble	Allergies/Hives	Cold Sores	Sickle Cell Anemia	Rheumatism	Dizzy Spells	Seizures
Bruise Easy	Nervous Disorder	Fainting	Mental Retardation	Arthritis	Hay Fever	Cortisone Meds.

When was your last physical examination? _____Physician's Name? _____
Has there been any change in your general health in the past year? _____If yes, for what reason? _____
Are you now under a physician's care? _____If yes, for what condition? _____
Is there anything related to your medical history that you have not indicated above? If yes, please explain:_____

Dental History

When was your last professional cleaning/exam? _____X-rays_____
What is your chief concern? _____

YES NO Are you having pain or discomfort at this time?
YES NO Do you have trouble chewing?
YES NO Do your gums bleed when you floss or brush?
YES NO Have you been told you have gum disease?
YES NO Do you dislike anything about your smile?
YES NO Do you feel nervous about dental treatment?
YES NO Have you ever had orthodontic treatment?
YES NO **Have you been advised to take antibiotics prior to dental treatment**?
YES NO Do you have dental implants?
YES NO Do you have frequent Headaches?

ATTENTION PATIENTS

You Are Responsible For Knowing Your Dental Insurance Benefits

Dental plans differ significantly. Each patient should know and understand his or her individual benefit package. Please contact your insurance company at the telephone number on your insurance card if you have questions regarding your coverage.

Patients with dental insurance are responsible for paying any co-payment, deductible, or fees for non-covered services at the time the services are rendered. We will be happy to give you an estimated treatment plan, however this is ***only an estimate*** and the patient is ultimately responsible for any payment not covered by insurance**.**

To help you get the most from your dental plan, we encourage you to become familiar with your insurance plan before seeking care.

X_____ _____

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

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental Care to third party payors and/or other health practitioners.

I authorize and hereby request insurance company to pay directly to the dentist (or the dental group) insurance benefits 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 on behalf of my dependent(s).

X_____ _____

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

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option in which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Payment in full at each appointment

_____CASH _____PERSONAL CHECK

_____CREDITCARD_____VISA_____MASTERCARD_____CARE CREDIT

CARD#_____EXPIRATION DATE_____

REGARDING MISSED AND CANCELLED APPOINTMENTS

At Putnam Family Dental, we strive to deliver our Best services at the most convenient times for our patients. It is for this reason we offer **LATE EVENING & WEEKEND** hours. This is why we will impose a **$50 "MISSED APPOINTMENT" fee PER HOUR** on appointments not cancelled and/or rescheduled within a timely manner. We ask that you kindly provide us with at least a **24-HOUR NOTICE OF CANCELLATION**.

X_____ _____

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