

## Registration Form

### Patient Information

Date \_\_\_\_\_  Mr.  Mrs.  Ms.  Dr.

Patient Name \_\_\_\_\_  
Last Name      First Name      Middle Initial

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Gender  Male  Female      Age \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

May we contact you at work?  Yes  No

Best time & place to contact you? \_\_\_\_\_

- Married       Widowed       Single  
 Separated       Divorced       Partnered

Occupation \_\_\_\_\_

Employer / School \_\_\_\_\_

Employer / School Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer / School Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Spouse Name \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Who may we thank for referring you (or how did you hear about us?) \_\_\_\_\_

Contact in case of an emergency: (preferably someone who does not live in your household)

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last      First

Phone ( \_\_\_\_\_ ) \_\_\_\_\_  Cell  Work  Home

### Dental Insurance Information

Name of person responsible for this account? \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other

Will you be using dental insurance?  Yes  No

Name of Insured (subscriber/employee) \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent  Other

Insurance Co. \_\_\_\_\_

Group #: \_\_\_\_\_ Policy # \_\_\_\_\_

Member ID #: \_\_\_\_\_

Is the patient covered by additional insurance?  Yes  No

If no 2<sup>nd</sup> insurance, please sign here \_\_\_\_\_

Name of Insured \_\_\_\_\_  
(with whom there is additional insurance)

Relationship to Patient:  Self  Spouse  Parent  Other

Name of Additional Insurance Co. \_\_\_\_\_

Group #: \_\_\_\_\_ Policy # \_\_\_\_\_

Member ID #: \_\_\_\_\_

### Assignment and Release

I certify that I, and/or my dependent(s), **only** have insurance coverage with \_\_\_\_\_,  
Name of dental insurance company (ies)  
and assign directly to Trinity Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submission, and my signature below will be used as "Signature on File".

Trinity Dental Care may use my health information and may disclose such information to the above name insurance company (ies), and their agents, for the purpose of obtaining payment for services and determining insurance benefits, or the benefits payable for related services. This consent will end when my current treatment plan is completed, or one year from the date signed below.

\_\_\_\_\_  
Name of Patient, Parent, Guardian or Responsible Party

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Responsible Party

\_\_\_\_\_  Self  Parent  Guardian  Responsible Party  
Date Relation to Patient

## Dental History

What is the reason for your visit today to our practice? \_\_\_\_\_

What would you like to accomplish today? \_\_\_\_\_

Name of your previous dentist? \_\_\_\_\_ City/State \_\_\_\_\_

Date of your last dental visit? \_\_\_\_\_ Date of your last dental x-rays? \_\_\_\_\_  
Month / Year Month / Year

Have you ever had Novocain or other local anesthesia?  No  Yes Ever fainted during dental treatment?  No  Yes

Have you ever had a reaction to a dental product or procedure?  No  Yes (please explain): \_\_\_\_\_

Have you had any complication during or after dental treatment?  No  Yes (please explain): \_\_\_\_\_

Do you wear dental prosthetics  No  Yes (Upper is:  full  partial / Lower is:  full  partial)

How old is the upper denture? \_\_\_\_\_ yrs. How old is the lower denture? \_\_\_\_\_ yrs.

### Please check if you have had issues with any of the following:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Sensitivity to cold     | <input type="checkbox"/> Jaw pain or tenderness         | <input type="checkbox"/> Periodontal (gum) treatment    | <input type="checkbox"/> Food sticks or collects between teeth |
| <input type="checkbox"/> Sensitivity to hot      | <input type="checkbox"/> Clicking or popping of jaw     | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Mouth sores or growths                |
| <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> Grinding or clenching of teeth | <input type="checkbox"/> Worn or chipped teeth          | <input type="checkbox"/> Bad breath or taste                   |
| <input type="checkbox"/> Sensitivity to sweets   | <input type="checkbox"/> Ear pain or tenderness         | <input type="checkbox"/> Dark teeth                     | <input type="checkbox"/> Shifting, spacing or flaring of teeth |

### Dental Care Evaluation

How often do you brush? \_\_\_\_\_ times per day. Toothbrush:  Electric  Soft  Medium  Hard

How often do you floss? \_\_\_\_\_ times per day. Do you use any other home care devices? \_\_\_\_\_

Is it difficult for you to brush or floss any area(s) of your mouth?  No  Yes (where): \_\_\_\_\_

Do your gums bleed when brushing or flossing?  No  Yes Do you have dry mouth?  No  Yes

Are you a smoker?  No  Yes ( Cigarettes  Pipe  Cigar) Do you chew tobacco?  No  Yes

Do you snack between meals on sweets, gum, potato chips, soda, juices, energy drinks?  No  Yes (please circle which ones)

Do you chew on both sides of your mouth?  No  Yes Have you had orthodontic treatment (braces)?  No  Yes

### Smile Evaluation

How do you feel about the appearance of your teeth? \_\_\_\_\_

Do you like the way your smile looks?  No  Yes If no, what don't you like? \_\_\_\_\_

Do you like the shape of your teeth?  No  Yes Do you like the color of your teeth?  No  Yes

Are there old fillings or dental work that does not look good to you?  No  Yes (please specify) \_\_\_\_\_

Do you have spaces between your teeth that you do not like?  No  Yes (please specify) \_\_\_\_\_

If you could change one thing about your smile, what would it be? \_\_\_\_\_

### Other History

Are you anxious about receiving dental treatment?  No  Yes (please specify what do you dislike) \_\_\_\_\_

Has fear or discomfort kept you from regular dental visits in the past?  No  Yes \_\_\_\_\_

Do you feel that keeping your teeth healthy has been a challenge?  No  Yes (why): \_\_\_\_\_

Do you have any concerns about getting your mouth healthy?  No  Yes (why): \_\_\_\_\_

Are there barriers that prevent you from getting optimum dental care?  No  Yes (please explain): \_\_\_\_\_

Is there anything else you would like us to know about the dental care you seek, or past dental experience(s)? \_\_\_\_\_

## Health History

To receive treatment in this office, you must answer all questions on this form. The questions asked relate directly to the safe and effective treatment you are to receive in the office. To the best of your ability, please give honest answers.

If you are unsure of a question, unsure of your answer, or whether the question relates to your medical condition, please discuss the matter with the dentist, or a member of the office staff.

Physician Name \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

Date of your last visit \_\_\_\_\_ Reason: \_\_\_\_\_ How is your general health?  Excellent  Good  Fair  Poor

Have you ever been hospitalized?  No  Yes (Date(s): \_\_\_\_\_ Reason: \_\_\_\_\_)

Are you taking Aspirin, or any other anticoagulant therapy?  No  Yes (please specify) \_\_\_\_\_

Do you have any difficulty with bleeding, or difficulty with healing from a cut, a wound or an extraction?  No  Yes

Are you taking, or have taken, any steroid or cortisone treatment in the past 2 years?  No  Yes (From: \_\_\_\_\_ To: \_\_\_\_\_)

Do you consume any alcoholic beverages?  No  Yes (How much: \_\_\_\_\_ How often: \_\_\_\_\_)

Do you have, or have had, any prosthetic replacements?  No  Yes (please specify): \_\_\_\_\_

Have you been asked to take antibiotic premedication before dental treatment?  No  Yes (Reason: \_\_\_\_\_)

Physician Name (who ordered premedication): \_\_\_\_\_ Physician's Specialty: \_\_\_\_\_

Do you now take, or have ever taken, any illegal drug(s)\*  No  Yes (specify): \_\_\_\_\_

**Medications\*** - Please list all medications you are currently taking (including over-the-counter drugs), describe the dosage/strength, and the reason you are taking these medications: \_\_\_\_\_

*\*Note: Accurate information about your current use of drugs and medications is critical. When drugs and/or medications used in routine dental care are mixed with other drugs and/or medications you are taking, they may cause complications, dangerous health problems, or may be fatal.*

**Allergies** - have you had any adverse reaction, or become ill from any the following (please check all that apply)?

Penicillin  Latex  Local anesthetic \_\_\_\_\_  Doxy/Tetracycline  Fluoride  Aspirin  Ibuprofen (Motrin, Advil, Nuprin)  
 Codeine  Silver  Jewelry/Metals  Iodine  Sulfa  Barbiturates  Dental product/material \_\_\_\_\_  Other \_\_\_\_\_

Pharmacy name: \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Please indicate if you have, or have had, any of the following conditions (by placing a mark "yes" or "no"):

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (type _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally (with extractions or surgery)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/intestinal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth (on head or neck)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough (persistent or bloody)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Radiation Treatment _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you aware of any other issues concerning your health?  No  Yes (please specify): \_\_\_\_\_

## Health History (con't)

### WOMEN

Have you ever taken any bisphosphonate medication:  No  Yes ( Fosamax  Boniva  Actonel  Skelid  Didronal)  
If yes, dates: (From: \_\_\_\_\_ To: \_\_\_\_\_) Dosage: \_\_\_\_\_

Are you pregnant, or is there a **possibility** that you are pregnant?  No  Yes Week #: \_\_\_\_\_ Estimated due date: \_\_\_\_\_

Are you nursing?  No  Yes Are you taking birth control pills\*?  No  Yes

*\*Please note that antibiotics may alter the effectiveness of birth control pills. Consult your physician/gynecologist.*

### DOCTOR NOTES

### CONFIDENTIALITY

All information you supply to this office (whether on this form, at the subsequent interview by the dentist or from any other source) will be held in the strictest confidence, and will not be disclosed without your express permission.

### PATIENT CERTIFICATION & CONSENT

*I have been informed that if I am uncertain about a question, or how the question relate to my health status, I must discuss the issue with the dentist or a member of the office staff.*

*I certify that I have read and understood the above questions.*

*I understand that honest answers to all the questions stated above are important to the provision of my dental care, and that I have answered them to the best of my ability.*

*I understand that if I ever have any change in my health, or if my medication(s) changes, I am to inform the dentist and/or this office at the next appointment, or the earliest possible time, without fail.*

*I have been assured that the information I provide will not be released without my express permission.*

*I hereby consent to allow diagnosis, proper dental care and treatment to be performed by this practice for myself (or the above named patient) until further notice. I understand there are no guarantees or warranties in health or dental care.*

\_\_\_\_\_  
**Name** of Patient, Parent, Guardian or Responsible Party

\_\_\_\_\_  
**Signature** of Patient, Parent, Guardian or Responsible Party

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name** of Doctor

\_\_\_\_\_  
**Signature** of Doctor

\_\_\_\_\_  
**Date**

### PERMISSION TO RELEASE INFORMATION

I grant the right to this office, and its staff, to release my health information, and information about my dental treatment, to health practitioners, and/or third party payers.

\_\_\_\_\_  
**Name** of Patient, Parent, Guardian or Responsible Party

\_\_\_\_\_  
**Signature** of Patient, Parent, Guardian or Responsible Party

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name** of Witness

\_\_\_\_\_  
**Signature** of Witness

\_\_\_\_\_  
**Date**