Welcome to Artistic Dentistry

Please Complete the Following Confidential Patient Registration Information

Patient Name _____ (First MI Last) Name you prefer to be called: _____

Home Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell _____

Birthdate _____ Please Circle Male Female

Social Security # _____ **Single** **Married** **Divorced** **Widowed** **Other**

Whom may we Thank for Referring You? _____ Spouse's Name _____

Person to Contact in Case of Emergency? _____ Contact Phone _____

Please Complete the Following Confidential Contact Information

Email Address _____

Please circle your contact preference: Home Ph. (call,voicemail) Cell Ph (call,voicemail) Email Text

Please indicate any Person with whom you give us permission to discuss your Dental Treatment, Appointments, or Fees:

Name _____ Phone _____ Relation _____

If you Have Dental Insurance, Please Complete the Following Information

Name of Insured _____ Relationship to Patient _____

Social Security or ID # of Insured _____ Birthdate of Insured _____

Employer or Group Name _____ Group Number _____

Insurance Company Name _____ Insurance Phone # _____

****If you have coverage with more than one Dental Insurance Company, Please let us know.****

Please read and sign below to acknowledge your HIPAA rights

My signature below indicates that I have been informed of my rights to privacy regarding my personal health information under the Health Insurance Portability & Accountability Act of 1996(HIPAA). I acknowledge that I have been offered a copy of the Federal HIPAA guidelines.

Printed Name _____ Date _____

Signature _____

Please read and sign below for Authorization, Release, and Agreement to Pay for Services

I hereby authorize the Doctor and/or staff to perform treatment mutually agreed upon by me. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks and I can ask for a complete recital of any possible complications. I authorize the release of any information and/or records rendered to me to other healthcare professionals and/or insurance companies when necessary to aid in my diagnosis and/or treatment. I hereby authorize my dental insurance carrier to pay directly to my dental provider for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage. I understand that payment is due at the time of service unless prior arrangements have been made. I agree to pay a billing fee, if balance is not paid within 35 days of the monthly billing date. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees in attempting to collect the balance on the account. I authorize this office to leave messages and/or mail correspondence to remind me of upcoming appointments. I understand that a broken appointment fee of $35.00 may be charged to my account if I miss an appointment or cancel with less than 48 hours notice.

Signature _____ Date _____

Artistic Dentistry Medical/Dental History

Please Complete the Following *Confidential* Medical/Dental History Information

Patient Name: _____ Date: _____

Primary Care Physician: _____ Dr. Phone #: _____

Medical Specialist: _____ Dr. Phone #: _____

Are you under ongoing Medical Care now? **YES** **NO** For what condition: _____

Any Surgery/Hospital visit within the last 3 years? **YES** **NO** Please explain Procedures/Conditions:

Do you take an **antibiotic pre-medication** prior to dental visits? Yes No Name of Medication: _____

Please List ALL **Medications/Supplements** you currently take: _____

Have you ever taken Bone Density Drugs? (Fosamax, Boniva, etc) **YES** **NO** Drug Name/How Long? _____

Please circle any medications/materials you are **Allergies** to? Anesthetics Latex Penicillin Sulfa Aspirin Metals Codeine

List any other **Allergies**: _____

Do you use tobacco and/or controlled substances? If yes, list type and frequency: _____

Have you ever had abnormal/prolonged bleeding? _____

For Women Only: Please Circle Yes or No: Pregnant - YES NO Nursing - YES NO Taking Oral Contraceptives? - YES NO

Please mark YES or NO for each item that you have now or have had before:

AIDS/HIV Positive	**YES**	**NO**	Cortisone	**YES**	**NO**	High Blood Pressure	**YES**	**NO**	Rheumatism	**YES**	**NO**
Alzheimer's	**YES**	**NO**	Diabetes	**YES**	**NO**	High Cholesterol	**YES**	**NO**	Shingles	**YES**	**NO**
Anemia	**YES**	**NO**	Drug Addiction	**YES**	**NO**	Hypoglycemia	**YES**	**NO**	Sickle Cell Disease	**YES**	**NO**
Angina	**YES**	**NO**	Emphysema	**YES**	**NO**	Irregular Heartbeat	**YES**	**NO**	Sinus Trouble	**YES**	**NO**
Arthritis/Gout	**YES**	**NO**	Epilepsy / Seizures	**YES**	**NO**	Kidney Problems	**YES**	**NO**	Spina Bifida	**YES**	**NO**
Artificial Joint	**YES**	**NO**	Fainting / Dizziness	**YES**	**NO**	Leukemia	**YES**	**NO**	Stomach Disease	**YES**	**NO**
Asthma	**YES**	**NO**	Frequent Cough	**YES**	**NO**	Liver Disease	**YES**	**NO**	Stroke	**YES**	**NO**
Blood Disease	**YES**	**NO**	Frequent Diarrhea	**YES**	**NO**	Low Blood Pressure	**YES**	**NO**	Swelling of Limbs	**YES**	**NO**
Blood Transfusion	**YES**	**NO**	Glaucoma	**YES**	**NO**	Lung Disease	**YES**	**NO**	Thyroid Disease	**YES**	**NO**
Bruise Easily	**YES**	**NO**	Heart Attack/Failure	**YES**	**NO**	Mitral Valve Prolapse	**YES**	**NO**	Tuberculosis	**YES**	**NO**
Cancer _____	**YES**	**NO**	Heart Murmur	**YES**	**NO**	Osteoporosis	**YES**	**NO**	Tumors or Growths	**YES**	**NO**
Chest Pains	**YES**	**NO**	Heart Pacemaker	**YES**	**NO**	Parkinson's	**YES**	**NO**	Ulcers	**YES**	**NO**
Cold Sores	**YES**	**NO**	Heart Disease	**YES**	**NO**	Psychiatric Care	**YES**	**NO**	Other Not Listed:	**YES**	**NO**
Congenital Heart Disorder	**YES**	**NO**	Heart Valve (Artificial)	**YES**	**NO**	Radiation / Chemo	**YES**	**NO**	_____		
Convulsions	**YES**	**NO**	Hemophelia	**YES**	**NO**	Renal Dialysis	**YES**	**NO**	_____		
COPD	**YES**	**NO**	Hepatitis Type____	**YES**	**NO**	Rheumatic Fever	**YES**	**NO**	_____		

Please List any Conditions not mentioned: _____

Do your gums bleed while brushing or flossing?	**YES**	**NO**	Do you wear dentures or partials? Yes No If Yes, How Old?____		
Are your teeth sensitive to hot/cold or sweet/sour?	**YES**	**NO**	Do you any sores or lumps in your mouth?	**YES**	**NO**
Are you experiencing any dental pain right now?	**YES**	**NO**	Do you have frequent headaches?	**YES**	**NO**
Have you ever had any neck, back, or jaw injuries?	**YES**	**NO**	Have you had orthodontic treatment?	**YES**	**NO**
Do you clench or grind your teeth?	**YES**	**NO**	Have you recently lost or gained weight?	**YES**	**NO**
Do you experience clicking/popping/pain in your jaw?	**YES**	**NO**	Are you happy with your smile?	**YES**	**NO**

Please inform us if you have any special needs during dental treatment _____

I certify that I have responded to the above information and to the best of my ability. I understand that providing incorrect information can be dangerous to my health. I will notify this office of any changes in my health or medications.

Signature of Patient (If patient is a minor, Signature of Guardian) Date