Patient Registration

P: 812-372-8590
F: 812-372-8934

Patient Information:

Name:______________________________ Birthdate:______________ Social Security #: ______________
FIRST NAME M.I. LAST NAME

Address:______________________________ City:______________ Zip Code: ______________

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer:__________________ Occupation:______________ Work Phone: ______________

Home Phone:__________________ Cell Phone:______________ Email:______________

Spouse:__________________ Birthdate:______________ Social Security #: ______________

Employer:__________________ Occupation: ______________________________

Work Phone:__________________ Cell Phone:______________ Email: ______________

If Patient is a minor, please complete the following:

Name of person responsible for this account:__________________ Relationship to Patient: ______________

Address:______________________________ City:______________ Zip Code: ______________

Cell Phone:______________________________ Birthdate:______________ Social Security #: ______________

Employer:______________ Occupation:__________________ Work Phone: ______________

General Information:

Other people involved in dental care: ______________________________

General Physician:______________ City:______________ Emergency Contact:______________ Phone: ______________

Dental Insurance Information:

Primary Insurance Company:__________________

Policy Holder:______________ DOB:__________

Patient's Relationship to Policy Holder:______________

Social Security # OR ID #:__________________

Secondary Insurance Company: __________________

Policy Holder:______________ DOB:__________

Patient's Relationship to Policy Holder: ______________

Social Security # OR ID #: __________________

Medical Insurance Information:

Primary Insurance Company:__________________

Policy Holder:______________ DOB:__________

Patient's Relationship to Policy Holder:______________

Social Security # OR ID #:__________________

Secondary Insurance Company: __________________

Policy Holder:______________ DOB:__________

Patient's Relationship to Policy Holder: ______________

Social Security # OR ID #: __________________

We would like to introduce you to our Patient Reminders Program:

Patient reminders are a way that we can make it easier for you to remember your appointment by sending you reminders via text message or email. Its benefits include being able to read the messages at your convenience without the interruption of a phone call.

You are also able to confirm your appointment electronically. We understand your time is valuable and it's sometimes challenging to receive our calls. Do you consent to receiving text or email reminders? We will utilize the contact information provided above.

☐ YES ☐ NO

Medical History Questionnaire

Patient Name:______________________ ______ __________________ **Date:** ________________________________
FIRST NAME M.I. LAST NAME

Current Medications & Supplements:
____

Preferred Pharmacy: ____

Do you have or have you had any of the following? *(Although some of the following questions may seem unrelated to your teeth, they are associated with proper management of your oral health and are confidential.)*

Heart Problems______________________ ☐Yes☐No
If yes, please describe___________________________
High blood pressure__________________ ☐Yes☐No
Low blood pressure___________________ ☐Yes☐No
Pacemaker__________________________ ☐Yes☐No
Artificial Heart Valve_________________ ☐Yes☐No
Joint Replacement____________________ ☐Yes☐No
If yes, please describe:___________________________
Is an antibiotic premed required prior to tx? ☐Yes☐No
Is so, what type/dosage___________________________
Do you experience shortness of breath after mild exercise?____________________________ ☐Yes☐No
Chest pain___________________________ ☐Yes☐No
Easy bruising________________________ ☐Yes☐No
Abnormal bleeding____________________ ☐Yes☐No
Frequent nose bleeds__________________ ☐Yes☐No
Anemia______________________________ ☐Yes☐No
Tuberculosis_________________________ ☐Yes☐No
COPD_______________________________ ☐Yes☐No
Hepatits, Type________________________ ☐Yes☐No
Liver problems_______________________ ☐Yes☐No
Kidney problems______________________ ☐Yes☐No
Bladder problems_____________________ ☐Yes☐No
Ulcers/digestive problems______________ ☐Yes☐No
Gallstones or gallbladder problems_______ ☐Yes☐No
Arthritis_____________________________ ☐Yes☐No
Back or neck pain_____________________ ☐Yes☐No
Osteoporosis_________________________ ☐Yes☐No
History of fainting____________________ ☐Yes☐No
Osteopenia__________________________ ☐Yes☐No
History of seizures____________________ ☐Yes☐No
Allergies____________________________ ☐Yes☐No
Circulatory problems__________________ ☐Yes☐No
Hepatitis/Jaudice_____________________ ☐Yes☐No
Food allergies________________________ ☐Yes☐No
Swelling of feet or ankles_______________ ☐Yes☐No
Thyroid problems_____________________ ☐Yes☐No
Snoring/sleep apnea___________________ ☐Yes☐No
Glaucoma/eye problems_______________ ☐Yes☐No

Epilepsy or other neurological disorder________ ☐Yes☐No
If other, what?____
History of head trauma_____________________ ☐Yes☐No
Frequent or severe headaches or migraines____ ☐Yes☐No
Thyroid concerns__________________________ ☐Yes☐No
Diabetes, Type:______, HbA1c:______________ ☐Yes☐No
Family history of diabetes__________________ ☐Yes☐No
Excessive thirst___________________________ ☐Yes☐No
Dry mouth________________________________ ☐Yes☐No
Oral herpes or cold sores___________________ ☐Yes☐No
HIV+ or acquired immune deficiency syndrome_ ☐Yes☐No
Have you received an organ transplant?_______ ☐Yes☐No
Have you donated an organ for transplant?____ ☐Yes☐No
Have you had cancer?______________________ ☐Yes☐No
If yes, type:____
If yes, medication/treatment:_______________________________
Have you taken Fosamaz/Boniva/Actonel/ Or Zometa?______________________________ ☐Yes☐No
Depression or anxiety______________________ ☐Yes☐No
History of alcohol abuse____________________ ☐Yes☐No
History of drug abuse______________________ ☐Yes☐No
Do you smoke?___________________________ ☐Yes☐No
If yes, how often?____
Do you use smokeless tobacco?_____________ ☐Yes☐No
If yes, how often?____

Women:
Date of last menstrual cycle:_______________________
Are you nursing?__________________________ ☐Yes☐No
Contraceptives or other hormones___________ ☐Yes☐No

Men:
Do you take medications for erectile dysfunction? ☐Yes☐No
Do you have a history of prostate cancer?______ ☐Yes☐No

Allergic reactions to any of the following:

Aspirin	Y/N	Penicillin	Y/N
Codeine	Y/N	Erythromycin	Y/N
Anesthetics	Y/N	Sulfa Drugs	Y/N
Zylocaine	Y/N	Iodine	Y/N
Novocain	Y/N	Latex	Y/N
Sedatives	Y/N		

Other Antibiotics:_________________________

Patient Signature:____ ***Date:***______________________

Doctor Signature:____

Dental Health Questionnaire

Please check any of the following problems that apply to you:

☐Sensitivity (hot,cold,sweet)
☐Tooth pain or discomfort when chewing
☐Headaches, earaches, neck pain
☐Jaw joint pain
☐Teeth or fillings breaking
☐Grinding or clenching teeth
☐Bleeding, swollen, or irritated gums
☐Loose, tipped, or shifting teeth
☐Bad breath or a bad taste in your mouth

Do you have or have you had any of the following:

☐Dentures
☐Partial denture
☐Braces
☐Periodontal (gum) treatments

Please share the following dates:

Your last cleaning ____/_____
Your last oral cancer screening _____/_____
You last complete x-rays_____/______

General Anesthesia Question (required)

Height:__________ Weight:___________

Have you ever had any unusual reactions or complications to medications or anesthesia?

☐Yes ☐No If yes, please explain:

____
____

Are you interested in whiter teeth?

☐Yes ☐No ☐I would like more information.

If you could change your smile, you would:

☐Make it brighter
☐Make it straighter
☐Close spaces
☐Replace black fillings with tooth colored fillings
☐Repair chipped teeth
☐Replace missing teeth
☐Replace old crowns that do not match
☐Have a smile makeover

On a scale of 1-10 with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

____
____

What is the most important thing to you about your dental visit?

____
____
____
____

1. Have you ever had any serious trouble associated with a previous dental experience? ☐Yes ☐No
   If yes, please specify: ____
2. Has there been an accident or medical event that may be the cause for you being here? ☐Yes ☐No
   If yes, please explain:____
3. Have you ever been treated by a periodontist/orthodontist/endodontist? ☐Yes☐No
   If yes, please explain:____

How did you hear about our office? *(Please check all that apply)*.

☐Current Patient:______________________________ ☐Radio ☐Health Fair ☐Google ☐Internet

☐Facebook ad ☐Newspaper ☐Direct Mail ☐BNI:_________________ ☐Website

☐Insurance ☐Other:________________

***Patient Signature*:____ *Date:*______________________**

***Doctor Signature*:____**

Patient Authorizations

________ ***I authorize*** the release of my dental records from Pawlus Dental and/or individuals involved in my dental care. I further authorize the release of records from any individuals to Pawlus Dental.

________ ***I authorize*** insurance payments to be made directly to Pawlus Dental. I understand I am responsible for any unpaid balance.

________ ***I am aware*** that should I not provide adequate notice to change an appointment, I may be charged a fee. (7 calendar days for a surgical appointment and 2 business days for a cleaning appointment or exam.)

________ ***I am aware*** of and have received notice of the Health Insurance Portability and Accountability Act (HIPAA).

Notice of Privacy Practice – Acknowledgment

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting us.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Authorization for Appointment Confirmation & Office Communications

As a courtesy to our patients, we often will give a variety of appointment reminders. Some of these reminders may generally include, but are not limited to, appointment post-cards sent through the mail, messages left with roommates/family members, voicemail messages, text messages, and emails. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's appointment time and date, or need for an appointment may be included.

By my signature below, I authorize Pawlus Dental and staff to confirm my appointments and remind me of the need for an appointment in the above-mentioned ways, for the duration of my treatment with their office.

Authorization to Discuss Treatment & Financial Information

By my signature below, I authorize Pawlus Dental and staff to discuss treatment and financial information with the people named below for the duration of my treatment with their office.

Name:____ Relationship to Patient:_________________________ Cell Phone: ____________________

Name:____ Relationship to Patient:_________________________ Cell Phone: ____________________

☐ I do not authorize Pawlus Dental to discuss treatment and financial information with anyone other than myself.

Patient's Signature:____ Date:______________________________

SUBMIT