Patient Registration Form.

Date: _____ **P.ID:** _____

Welcome to Sweet Tooth Dentistry, your dental home! Our office looks forward to provide you with exceptional dental care. To assist us in serving you better, please complete both sides of the following confidential form.

First Name: _____ Last Name: _____ Prefer to be called: _____

Date Of Birth: _____ Age: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Best Way To Contact: ○ Cell ○ Text ○ Email ○ Home Best Time To Contact: ○ Morning ○ Evening

May we contact you by Text/Email ○ Yes ○ No Intials: _____ Email: _____

How did you hear about us: _____ Are other family members pt. at our office: ○ Yes ○ No Name: _____

Emergency contact: _____ Phone: _____ ID for prescription: _____

Family Physician: _____ Phone: _____ Address: _____

Financial Agreement / Authorization

Person Responsible for Account ○ Self ○ Other:

Name: _____ Relationship: _____ Phone No.: _____

Minors must be accompanied by a parent or legal guardian. If the parents are not together, the person accompanying will be responsible for the treatment and payment of the service. We accept the following forms of payment: Cash/ Card/ Insurance Assignment. We do not accept personal cheques. Please provide following information for assignment purposes.

Primary Insurance Plan _____

Name: _____ DOB: _____

Occupation: _____ Employer: _____

Group No.: _____ Policy No.: _____

○ Assignment ○ Non-Assignment

Secondary Insurance Plan _____

Name: _____ DOB: _____

Occupation: _____ Employer: _____

Group No.: _____ Policy No.: _____

○ Assignment ○ Non-Assignment

As a professional courtesy to our most valued patients, we will accept insurance assignment under the following terms and conditions:

1. Any amounts not paid for under your insurance plan and due to our office will be paid by you. Payment is due at the time of service, including any deductibles or co-payments.

2. When your treatment requires laboratory services, a deposit equal to the estimated laboratory fee is required at the time that your dental impressions are taken.

3.While we will do our best to obtain accurate information regarding your eligibility and benefits, in some cases the insurance companies will not provide us with the most up to date information resulting in inaccuracies. No estimate is a guarantee of payment. Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

4. If full payment has not been made within 30 days of the claim submission any outstanding balance will be your responsibility should your insurance company deny all, or a portion of your claim. The balance will be charged to your credit card on file and a receipt of any charges will be mailed to you.

I have read or have had read to me the privacy and office policies and insurance assignment conditions. I understand that I am responsible to pay for all dental fees charged to me for services provided. My signature below is authorization of the assignment of my Dental Insurance payment to Sweet Tooth Dentistry. If my plan denies payment of my benefits to Sweet Tooth Dentistry, I agree to pay my account in full.

SIGNATURE of Patient, Parent/Guardian: _____ Date: _____ Witness: _____

I hereby authorize Sweet Tooth Dentistry to process payment to my credit card of any outstanding balance for dental treatment.

Credit Card No: _____ CVV: _____ Exp. Date: _____

Name on Card: _____ Signature: _____ Date: _____

Your appointment will be reserved just especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it will be necessary to charge for the time lost.

Please do not hesitate to ask our staff should you have any question regarding any office policy. (Turn page)

Medical and Dental history: Name: _____ Age: _____ Date: _____

Please do not hide any information. Any unrevealed information may affect your treatment. Please fill appropriate boxes:

1. Reason for today's visit? _____
2. Does any of your teeth hurt? _____
3. When was your last dental cleaning and check-up? _____
4. Previous dentist visited: _____
5. Ever had dental: ☐ Injury ☐ Surgery ☐ Gum Surgery ☐ Braces
6. Is your sugar/snack intake: ○ High ○ Medium ○ Low
7. Do you floss regularly? ○ Yes ○ No
8. Brushing: ○ Vigrous ○ Light How often? _____ /day
9. Do you have any concerns regarding dental visit?
   ☐ Time ☐ Money ☐ Fear ☐ Other _____
10. Do you have other dental concern? _____
11. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Spontaneously
12. Do you suffer from pain and /or swelling of your gums? ○ Yes ○ No
13. Are you aware of any loose teeth? ○ Yes ○ No
14. Are any of your teeth sensitive to? ☐ Cold ☐ Sweet ☐ Heat ☐ Other
15. Do you grind or clench your teeth during the day or night? ○ Yes ○ No
16. Does your jaw click or pop when opened widely? ○ Yes ○ No
17. Do you have any difficulty in opening or closing your jaw? ○ Yes ○ No
18. Do you feel dry mouth during day time? ○ Yes ○ No
19. Have you had any growth or sore spots in your mouth? ○ Yes ○ No
20. Would you rate your current dental health as: ○ Good ○ Fair ○ Poor

Medical History

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

☐ Angina, Chest Pain	☐ Diabetes	☐ High Blood Pressure	☐ Respiratory/Lung Disease	☐ Thyroid Condition
☐ Shortness of Breath	☐ Hypoglycemia	☐ Low Blood Pressure	☐ Kidney Disease	☐ Tuberculosis
☐ Heart Attack	☐ Hepatitis A, B, C	☐ Dizziness/Fainting	☐ Liver Disease	☐ Asthma
☐ Heart Disease	☐ Implant/Transplant	☐ Bleeding Disorder	☐ Stomach Ulcers	☐ Sinus Problems
☐ Artificial Heart Valve	☐ AIDS/HIV	☐ Anemia	☐ Psychiatric Condition	☐ Arthritis
☐ Pacemaker	☐ Cancer/Malignancy	☐ Stroke	☐ Epilepsy/Seizures	☐ Osteoporosis Medication
☐ Infective Endocarditis	☐ Artificial Joints	☐ Alcohol Dependency	☐ Cerebral Palsy	☐ Bulimia
☐ Heart Murmur	☐ Radiation/chemotherapy	☐ Drug Dependency	☐ **None**	☐ **Others** _____

1. Are you presently under the care of a physician? ○ Yes ○ No
2. Have you had a medical examination in the last year? ○ Yes ○ No
3. Have you ever been hospitalized for illness or surgery? ○ Yes ○ No
4. Do you use any prescription or non-prescription drugs? ○ Yes ○ No

   Please List:
5. Have you been warned against taking any medication? ○ Yes ○ No

   Please List:
6. Do you have any allergies? ○ Yes ○ No

   Please List:
7. Have you ever had any injury or surgery to face or jaw? ○ Yes ○ No
8. Do you have frequent / severe headaches? ○ Yes ○ No
9. Do you bruise or bleed abnormally/more? ○ Yes ○ No
10. Is there any medical condition that runs in the family?
    (Like Diabetes, High blood pressure, Cancer, etc.) ○ Yes ○ No

    Please List:
11. Do you faint (pass out) frequently? ○ Yes ○ No
12. Have you ever had any heart condition? ○ Yes ○ No
13. Have you had any recent change to your health? ○ Yes ○ No
14. Is there anything about you we should be aware of? ○ Yes ○ No

    Please List:
15. Do you smoke? ○ Yes ○ No If yes, No. of years_____ Cigr./day_____
16. Have you ever smoked? ○ Yes ○ No
17. Do you smoke pot/weed? ○ Yes ○ No ; Smoked in last 24hrs?_____
18. Women: Pregnancy ○ Yes ○ No

    Breastfeeding: ○ Yes ○ No OCP: ○ Yes ○ No

I understand that the information that I have given today is correct to the best of my knowledge and haven't omitted any information. I also understand that it is my responsibility to inform this office of any changes in my medical status. I have had the opportunity to ask questions and I also consent my physician being contacted if necessary. I hereby authorize the dentist or designated staff to perform diagnostic, dental and oral surgery procedures and services.

Notes: _____ BP: _____ Hb1AC/B.Sugar: _____

Patient/ Parent's (Guardian) Signature: _____ Date: _____ Dentist: _____