



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: Vigorous 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:

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