

Patient Registration Form

Email:			Today's Date:		
Preferred Name: <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Referred by:		
Name: Last First Middle		Home Phone: <i>include area code</i> () ()		Cell Phone: <i>include area code</i> () ()	
Address: Mailing address			City:		State: Zip:
SS#:		Date of Birth:		Sex: M F	
Employer:			Business Phone: <i>include area code</i> () ()		
Emergency Contact:		Relationship:		Home Phone: <i>include area code</i> () () Cell Phone: <i>include area code</i> () ()	
College Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Please provide school info:			School Name: _____		
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired			Address: _____		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Address 2: _____		
Pref. Pharmacy: Phone: () ()			City, State, Zip: _____		

Dental Insurance Information

Primary Insurance Information	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	
Secondary Insurance Information	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	

Dental Information

For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time?			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays:			
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Yes No DK	Yes No DK
Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physician Name: _____ Phone: include area code (_____) _____ Address/City/State/Zip: _____	Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what was the illness or problem? _____
Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what condition was treated? _____ Date of last physical exam: _____	Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____ _____
Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED
Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Treatment Began: _____	WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Number of weeks: _____ Taking birth control pills or hormone replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?
Date: _____ If yes, have you had any complications? _____

Allergies - Are you allergic to, or have you had a reaction to: **Yes No DK**
To all **yes** responses, specify type of reaction.

Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbituates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay fever / seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Yes No DK	Yes No DK	Yes No DK	Yes No DK
Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, date: _____	Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Artificial heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Recurrent infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	G.E. Reflux/Persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Type of infection: _____
Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Coronary artery disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe headaches/Migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Cancer/Chemotherapy/ Radiation treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
Name of physician or dentist making recommendation: _____ Phone: (_____) _____

Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
Signature of Patient/Legal Guardian: _____ Date: _____

GLAD

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IMPORTANT POLICY NOTICE REGARDING INSURANCE AND PAYMENT

We will file your insurance as a courtesy to you and will accept "assignment of benefits" on your behalf. Regardless of what we may calculate your insurance company will pay, it is only an estimate. The financial obligation for dental treatment is between you and this office and is not between this office and your insurance company.

We will do all we can to get the maximum benefits reimbursed for you. But please be aware that some of the services provided may not be covered or may be considered above "usual and customary". You are responsible for the payment of your account.

We have flexible payment arrangements but expect those arrangements to be discussed at the time of your visit. We can accept the following payment methods:

Please indicate your preferred method of payment below

Cash

Personal Check

Credit Card (Visa, Mastercard, American Express, Discover)

Automatic Monthly Payments to your credit card

Care Credit (As us about this healthcare credit card with flexible payment plans)

I understand the above payment policy:

X _____

Print Name

Date

GLAD DENTAL APPOINTMENT CANCELLATION POLICY

We strive to provide excellent dental care to you and the rest of our patients. To be respectful to our staff and the rest of our patients, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all our patients. We require that you give our office **48 hours' notice if you need to reschedule your appointment. For Monday patient, we require you cancel by Friday if need be.** If you miss an appointment without contacting our office in the provided time, it will be considered a missed appointment; The **dentist fee is \$75.00** and the **hygienist fee is \$50.00**, and will be charged to your account. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is **more than 15 mins late** without prior notice for a scheduled appointment, we will consider this a missed appointment and the appropriate fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

We thank you for your understanding.

I have read and understand the **Appointment Cancellation Policy** of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I _____ (print name), agree to the terms of the cancellation policy.

Date _____

COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

I, _____ (Print name), knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing. Dental procedures create water spray one way the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

-I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _____ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

-Fever

-Shortness of breath

-Dry cough

-Runny nose

-Sore throat

_____ (Initial)

I understand that the CDC recommends social distancing of at least 6 feet and that this is not possible in dentistry.

_____ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus.

-I verify that I have not traveled outside the United States in the last 14 days _____ (Initial)

-I verify that I have not travelled via airline, bus, or train within the last 14 days _____ (Initial)

I have discussed with my dentist the pros and cons of my dental treatment in relation to contracting COVID-19.

I am satisfied that my dentist answered all of my questions.

Although there are no guarantees in regards to the possibility of contracting COVID-19, my dentist and his staff will be following safety protocols as to best protect myself and the staff during treatment. I understand that I have the possibility to delay my treatment, and I have elected to have the procedure at this time.

Signature: _____ Date: _____

Temperature (taken in office): _____ Time taken: _____