Patient Registration

Personal Information

Patient Full Name ________________________ Preferred Name ______________ Birth Date ___________

Home Address __________________________ City ________________ State_____ Zip ____________

SS# ____________ Home # (   ) ___________ Cell Phone # (   ) ___________ Work # (   ) ___________

Email Address ________________________ Spouse's Name ___________ Referred By ________________

Emergency Contact (Guardian if a minor) __________________ Relationship __________ Phone # (   ) ________

Employer ______________________________ Do you have dental insurance : Yes □ No □

Reason for visit ____

Circle any service you would like to discuss further

Implants   Cosmetic Services   Sedation   Teeth Straightening/Ortho   Snoring/Sleep Apnea

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Medical Information

Yes or No - Are you currently under the care of a physician?
Yes or No - Are you allergic to any medications? List ________________
Yes or No - Are you pregnant? How many weeks? ___________________
Yes or No - Do you have any artificial joints? When and what joint? ____________________
Yes or No - Do you have any history of infective endocarditis or heart transplant?
Yes or No - Do you have history of prosthetic heart valve repair or congenital heart defect?
Yes or No - Have you ever taken any bisphosphonate therapy including Fosamax, Boniva, Reclast,Actonel, etc?
Yes or No - Do you take blood pressure medication?
Yes or No - Do you have a history of heart attack or stroke?
Yes or No - Do you take or have recently taken blood thinners? List________________
Yes or No - Do you have any bleeding disorder?
Yes or No - Do you have diabetes?
Yes or No - Do you have kidney disease?
Yes or No - Do you have liver disease?
Yes or No - Do you smoke, chew or dip tobacco?
Yes or No - Do you have a history of drug addiction or use?
Yes or No - Do you have HIV or Hepatitis B or C?
Yes or No - Do you have a history of cancer?
Yes or No - Do you take medication for anxiety?
Yes or No - Do you take medication for or have ever been treated for any psychiatric condition?
Yes or No - Do you have a history of periodontal disease?
Yes or No - Do you have a history of grinding your teeth (bruxism)?
Yes or No - Do you have a history of TMJ pain?

Please list any major illness, hospitalization, or condition not listed above___________________________

Please list current medications____

Please list treating medical doctors that you are under the care of_________________________

I verify that the preceding information is true. I authorize the release of information to my insurance company. I authorize release of any information relating to my claim. I authorize payment directly to Hopewell Family Dentistry. I understand all fees not paid by my insurance company is my responsibility. I will allow the Doctors and Staff of Hopewell Family Dentistry to discuss my conditions with my physicians(s) and specialist and to request information from them. I acknowledge that I have been given or offered a copy of the office's "Notice of Privacy Practice" as well as "Hopewell Family Dentistry's Financial and Appointment Policies".

Signature________________________ Date ________________