HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Whom May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE

EMPLOYER _____ OCCUPATION _____

SOC. SEC. # _____ BIRTHDATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY, STATE _____

HOME PH. _____ CELL PH. _____

WORH PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ Group # _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. #or Enrollee ID # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure?	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)?	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist?

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # 4 LACK of concern # 4

COST of treatment # 4 MISSING work time # 4

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO
AIDS/HIV Pos.	☐	☑
Anemia	☐	☑
Arthritis (Rheumatism)	☐	☑
Artificial Heart Valves	☐	☑
Artificial joints	☐	☑
Asthma	☐	☑
Atopic (Allergy Prone)	☐	☑
Back Problems	☐	☑
Bleeding abnormally, with extraction surgery	☐	☑
Blood Disease	☐	☑
Cancer	☐	☑
Chemical dependency	☐	☑
Chemotheropy	☐	☑
Circulatory problems	☐	☑
Congenital Heart Lesion	☐	☑
Cortisone treatments	☐	☑
Cough(persistent or bloody)	☐	☑
Diabetes	☐	☑
Epilepsy	☐	☑
Emphysema	☐	☑
Fainting	☐	☑
Food allergies	☐	☑
Glaucoma	☐	☑
Headaches	☐	☑
Heart murmur	☐	☑
Heart problems(please describe)	☐	☑
_____		
Hemophilia(Abnormal bleeding)	☐	☑
Herpes	☐	☑
Hepatitis Type _____	☐	☑
High blood pressure	☐	☑
Jaw pain	☐	☑
Jaundice	☐	☑
Kidney disease	☐	☑
Liver disease	☐	☑
Low Blood Pressure	☐	☑
Material allergies (latex, wool, metal, chemicals)	☐	☑
Mitral valve prolapse	☐	☑
Nervous problems	☐	☑
Pacemaker/heart surgery	☐	☑
Psychiatric care	☐	☑
Rapid weight gain/loss	☐	☑
Radiation treatment	☐	☑
Respiratory disease	☐	☑
Rheumatic/scarlet fever	☐	☑
Shingles	☐	☑
Shortness of breath	☐	☑
Skin rash	☐	☑
Sinus Trouble	☐	☑
Stroke	☐	☑
Surgical implant	☐	☑
Swelling of feet or ankle	☐	☑
Thyroid disease/problems	☐	☑
Tobacco habit	☐	☑
Tonsillitis	☐	☑
Tuberculosis	☐	☑
Ulcer/Colitis	☐	☑
Venereal disease	☐	☑
Other: _____		
_____		

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin ☐ Local Anesthetic ☐ Erythromycin ☐ Latex (balloons, gloves, etc.) ☐

Nitrous Oxide ☐ Codeine ☐ Penicillin ☐

Are you aware of being allergic to any other medications or substances?

If yes, list:

Is there any other Medical or Dental information that you feel I should know about? _____

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

Routsong Family Dentistry
OFFICE POLICIES

Our philosophy is to provide the highest quality of patient education and dental care to all of are patients. To ensure that you begin with a positive experience we have prepared the following information for you to review. Please fell free to let us know if you have any questions or concerns.

Patient Name:_____ **Date:**_____

EXPECTED PAYMENT

In order to keep our fees as low as possible, we ask that payment be made at the time of service.
For your convenience, we will provide you an estimate for service in advance of your appointment/s to ensure you the opportunity to plan in advance for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want.

_____
Initials

DENTAL INSURANCE

We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We ask that you familiarize yourself with your insurance benefits, and provide us the correct information for submittal of your claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 60 days. Please remember that your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee any estimated coverage. Not all services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you as indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums.

_____
Initials

PAYMENT OPTIONS

For your convenience, we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. Please identify which form of payment is most convenient for you at the time of service.

Cash / Check ☐ **Visa / MasterCard** ☐ **Extended Payment** ☐

PAST DUE BALANCES

If applicable balances owing from a prior visit where insurance is not pending, or an insurance payment has not been received within **90-days**, or an account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. All balances over 60-days are subject to a **$10** rebilling fee. We will charge a fee of **$25** for each check that is returned un-payable by your bank.

_____
Initials

CANCELLATION NOTICE

If you are unable to keep your appointment we request you provide us with a 48-hour advance courtesy notice. Early notification ensures that we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient; therefore filling the time previously reserved for you. We realize that emergencies do occur and we will be flexible under those circumstances.

_____

Initials

INFORMATION CHANGES

To ensure your records are current please notify us of any changes related to your medical history, telephone number/s, address, employer or insurance informatiob as they occur.

_____

Initials

Notice of Privacy Practices & Dental Material Fact Sheet

I have read and received a copy of this office's Notice of Privacy Practices and a I read and received a copy of the Dental Material Fact Sheet titled, "Facts About Fillings".

_____

Initials

My signature indicates that I understand the policies as outlined and any questions I have with regard to office ploicies have been answered.

_____ _____

Signature of Responsible Party or Patient Date

My signature indicates that I have reviewed the office policies with the responsible party and/or patient.

_____ _____

Signature of Staff Member or Doctor Date