

PATIENT REGISTRATION

Patient Number ABC		Today's Date _____	
Patient's Name		Sex: M F	Birthdate
Home Address		City	State Zip
<i>Please Circle One:</i> Single Married Separated Widow		Your Soc. Sec. #	
Home Ph.#	Cell Ph. #	E-mail Address	
Your Employer	Work Ph. #	How Long Employed	
Are you a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If patient is minor we need:</i>		<i>Mother's DOB</i>	<i>Father's DOB</i>
Person responsible for account		Driver's License #	Relationship
Name of spouse (parent if minor)		Spouse's (parent's) Soc. Sec. #	
Spouse's (parent's) Employer	Work Ph. #	Cell Ph. #	
EMERGENCY INFORMATION <i>Name, address, & telephone of a relative not living with you</i>			

Reason for this visit _____

How did you hear about our office? _____

DENTAL INSURANCE INFORMATION (Primary Carrier)	If you have double digit insurance coverage, complete this for the 2nd coverage
Insured's name	Insured's name
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone # DOB	Phone # DOB
SS#	SS#
Group # Local #	Group # Local #

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Patient Signature (Parent if child)

Date

DENTAL HISTORY

Please check any of the following problems that apply to you.

- | | | |
|---|--------------------------|--------------------------|
| -Sensitivity (hot; cold, sweet, pressure) | Yes | No |
| Where? UR LR UL LL | <input type="checkbox"/> | <input type="checkbox"/> |
| -Headaches, earaches, neck pain | <input type="checkbox"/> | <input type="checkbox"/> |
| -Jaw joint pain | <input type="checkbox"/> | <input type="checkbox"/> |
| -Teeth or fillings breaking | <input type="checkbox"/> | <input type="checkbox"/> |
| -Grinding or clenching teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| -Bleeding, swollen or irritated gums | <input type="checkbox"/> | <input type="checkbox"/> |
| -Loose, tipped or shifting teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| -Bad breath | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have or have you had any of the following? | | |
| -Dentures | <input type="checkbox"/> | <input type="checkbox"/> |
| -Partial dentures | <input type="checkbox"/> | <input type="checkbox"/> |
| -Braces | <input type="checkbox"/> | <input type="checkbox"/> |
| -Periodontal (gum) treatments | <input type="checkbox"/> | <input type="checkbox"/> |

Please share the following dates:

- Your last cleaning _____ / _____
- Your last oral cancer screening _____ / _____
- Your last complete X-Rays _____ / _____

Name of Previous Dentist _____
 City _____ State _____
 Phone Number _____

- | | | |
|---|--------------------------|--------------------------|
| If you could whiten your teeth for a cost anyone could afford, would you do it? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke or use chewing tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| How much? _____ For how long? _____ | | |
| If I could change my smile, I would: | | |
| -Make it whiter | <input type="checkbox"/> | <input type="checkbox"/> |
| -Make it straighter | <input type="checkbox"/> | <input type="checkbox"/> |
| -Close spaces | <input type="checkbox"/> | <input type="checkbox"/> |
| -Replace black metal fillings with tooth colored restorations | <input type="checkbox"/> | <input type="checkbox"/> |
| -Repair chipped teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| -Replace missing teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| -Replace old crowns that don't match | <input type="checkbox"/> | <input type="checkbox"/> |
| -Have a smile makeover | <input type="checkbox"/> | <input type="checkbox"/> |

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

- How important is your dental health to you?
 1 2 3 4 5 6 7 8 9 10
- Where would you rate your current dental health?
 1 2 3 4 5 6 7 8 9 10
- Where do you want your dental health to be?
 1 2 3 4 5 6 7 8 9 10
- Why did you leave your previous dentist? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

- | | | | | | | | | | | | |
|------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|
| AIDS | YES | NO | Dizziness | YES | NO | HIV Positive | YES | NO | Scarlet Fever | YES | NO |
| Allergies (Seasonal) | <input type="checkbox"/> | <input type="checkbox"/> | Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> | HPV (Human Papilloma Virus) | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina (Chest pain) | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Jaw Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Joints | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Heart Conditions | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart Lesions (Congenital) | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness/Depression | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Bruise Easily | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant Currently | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | | |
| Cervical Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> | Radiation (head/neck) | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Cortisone Medication | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis C | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |

Are you allergic or have you reacted adversely to any of the following medications?

- | | | | | | | | | | | | | |
|---------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|------------|--------------------------|--------------------------|-------------|
| Aspirin | YES | NO | Percodan | YES | NO | Tetracycline | YES | NO | Valium | YES | NO | Other _____ |
| Darvon | <input type="checkbox"/> | <input type="checkbox"/> | Latex | <input type="checkbox"/> | <input type="checkbox"/> | Codeine | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Nitrous Oxide | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetic | <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Have you ever taken any the following medications?

- | | | | | | |
|---------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|
| Actonel | YES | NO | Zometa | YES | NO |
| Aredia | <input type="checkbox"/> | <input type="checkbox"/> | Boniva | <input type="checkbox"/> | <input type="checkbox"/> |
| Fosamax | <input type="checkbox"/> | <input type="checkbox"/> | Herbal | <input type="checkbox"/> | <input type="checkbox"/> |
| Reclast | <input type="checkbox"/> | <input type="checkbox"/> | Supplements | | |

Are you under a physician's care? What for? _____

What medications are you currently taking? _____

Family Physician _____ Phone Number _____

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

 Patient Signature (Parent if child)

 Date

 Dentist Signature

ALL ASPECTS DENTAL GROUP QUESTIONNAIRE

**To be completed at every appointment

Please initial after every question

1) Are there any changes in your medical history, personal information or dental health?

If yes, please describe _____

Initials _____

2) Have you taken the following medications: Alendronate (*Fosomax*), Ibandronate (*Boniva*), Risedronate (*Actonel*), Pamidronate (*Aredia*), Zoledronic acid (*Zometa*), Xgeva (Denosumab)?

Yes___ No___

Initials _____

3) Are there any changes with your insurance (if applicable)? Yes___ No___

If yes, please describe _____

**Failure to notify any changes will make you responsible for full charges for today's procedures.*

Initials _____

4) Do you want to change anything with your smile? Yes ___ No ___

If yes, please circle what you would like to change:

a) color b) position c) missing teeth d) other (please describe) _____

5) In any litigation that All Aspects Dental Group is required to file to collect it's fees due for services rendered or for any other reason that litigation is initiated or defended. All Aspects Dental Group shall be entitled to recover from the Patient or Guardian/Provider for Minors reasonable attorney's fees, costs, and expenses. Initials _____

6) We are an **AMALGAM FREE** dental practice. We **ONLY** use composite fillings. Your insurance may or may not cover this type of filling. The patient is responsible for any charges your insurance DOES NOT cover. Initials _____

7) We do an **oral cancer screening** once a year. There is a charge for this procedure of **\$25.00**; your insurance may or may not cover this screening. The patient is responsible for any charges your insurance DOES NOT cover. Initials _____

8) Do you have popping, clicking, locking or soreness of the jaw? Yes___ No___

Initials _____

9) Do you or have you been told that you snore / stop breathing while sleeping? Yes___ No___

Initials _____

*Comments:

Signature _____ Date _____

Print Name _____ E-mail _____

TMJ HEALTH QUESTIONNAIRE

Name _____

Date _____

CHIEF CONCERN _____

DATE OF ONSET _____

PAIN SYMPTOMS

Do you get headaches?	Y	N	Do you get headaches in the right or left temple areas?	Y	N
Do you get migraine headaches?	Y	N	Do you get headaches in the front or back of your head?	Y	N
Do you frequently have neck aches or stiff neck muscles?	Y	N	Do you clench your teeth during the day?	Y	N
Have you ever had chronic shoulder or back pain?	Y	N	Do you clench your teeth at night?	Y	N
Do you have trouble sleeping soundly?	Y	N	Do you grind your teeth when asleep?	Y	N
Are your jaws tired when you awaken?	Y	N			
Are your teeth sore when you awaken?	Y	N	When are your pain symptoms the worst?		

Have your wisdom teeth been extracted? Y N

Does anything make you feel better?

What medications, if any, are you taking?

How often do you take medication for relief of pain?

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw?	Y	N	Have you ever been involved in any serious accidents, such as a car accident?	Y	N
Any whiplash neck injuries?	Y	N	Details _____		

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal?	Y	N	Do you feel or hear a 'clicking', 'popping' or 'cracking' noise from either jaw joint?	Y	N
Are there any foods you avoid eating?	Y	N	Has your jaw ever locked when you were unable to open or close?	Y	N
Do you ever get dizzy?	Y	N	Do you have difficulty opening wide or yawning?	Y	N
Do you ever feel faint?	Y	N	Have you ever had pain in either jaw joint?	Y	N
Do you ever feel nauseated?	Y	N	Does your jaw ache when you open wide?	Y	N
Is there a family history of jaw joint (TMJ) problems or headaches?	Y	N			

EAR AND EYE SYMPTOMS

Do you have pain in either ear?	Y	N	Do you wear glasses or contacts?	Y	N
Do you suffer from any loss of hearing?	Y	N	Are there times when your eyesight blurs?	Y	N
Do you have itchiness or stuffiness in either ear?	Y	N	Do you get pain in, around or behind either eye?	Y	N
Do you hear ringing, buzzing, or hissing sounds in either ear?	Y	N			

BREATHING

Do you have allergies?	Y	N	Is your nose stuffed when you don't have a cold?	Y	N
Do you have sinus problems?	Y	N	Have you been diagnosed with Sleep Apnea?	Y	N
Do you snore at night?	Y	N	Have you had a sleep study done at a Sleep Clinic (hospital)?	Y	N