New Patient Registration Form

Name: _____
Last First MI Title

Preferred Name: _____ ☐ Male ☐ Female

Address: _____ City _____ State _____ ZIP _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: Single Married

How did you hear about our office? _____

Do you prefer to be contacted for appointment confirmation via e-mail or phone? *(Please circle preference)*

Insurance – Primary

Insurance Company Name: _____

Insurance Company Phone: _____ Group Number: _____

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to **Modern Dentistry of St. Cloud** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient or Guardian Signature: _____

Acknowledgement of receipt of notice of privacy practices

In Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") a notice that describes how medical information about you may be used and disclosed and how you can get access to this information is posted in the RECEPTION room. Should I desire to have a printed copy of this NOTICE, I will check the following box and notify the RECEPTIONIST:

- I DO WANT A COPY OF THE 'NOTICE'
- I DO NOT WANT A COPY OF THIS 'NOTICE'

Signature: _____ Date: _____

Circle One: **Adult Patient** **Father** **Mother** **Husband** **Wife** **Guardian**

Modern Dentistry of St. Cloud

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants placed? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No

Please list each one: _____

Have you ever had any surgical procedures? ☐ Yes ☐ No

Please list each one: _____

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery Fainting
☐	☐	Spells
☐	☐	Fever Blisters Frequent
☐	☐	Headaches

Yes	No	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Disease
☐	☐	Shingles

Yes	No	Conditions
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

☐	☐	Are you currently pregnant?
☐	☐	Are you Nursing?
☐	☐	Have you ever been diagnosed with _____ Osteoporosis/Osteopenia?

Do you have any medical condition(s) that is not listed above? Please list all.

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ **Date**: _____

Reviewed by Doctor_____ **Date** _____

Modern Dentistry of St. Cloud

Dental History

What are your main concerns today? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ☐ Yes ☐ No

Are you under stress? (newjob,moving,relationships) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times a do you: floss/week?_____brush/day?_____

Are your teeth sensitive to hot, cold or anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at **Modern Dentistry of St. Cloud** we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Teeth Whitening	Dental Veneers	Invisalign
Root Canals	Smile Makeover	Bonding
Sealants	Crown and Bridge	Implant Crowns
Partials/Dentures	Night/Sport Guards	

Others (Please specify):_____