Patient Registration

Information will be held in the strictest of confidence.

PATIENT INFORMATION

Patient Name	Date	
Address	Social Security #	
City, State, Zip	Birth date	Age
☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Minor	Home Phone	
Patient Employer / School	Work Phone	Ext.
Address	Cell Phone	
City, State, Zip	E-mail	
Occupation	Best time and place to call?	
Whom may we thank for referring you?		
Who is responsible for this account?	Relation:	

Your **SPOUSE**
Name
Birth Date
SS#
Employer
Work Phone
IN CASE OF EMERGENCY, CONTACT Someone who does not live in your household
Name
Relationship
Phone 1
Phone 2

DENTAL INSURANCE	
Subscriber's Name	
Relation to patient	Subscriber ID:
Insurance Co.	
Group #	Phone
Is patient covered by additional insurance?	☐ Yes ☐ No
Subscriber's Name	
Birth date	SS#
Relation to patient	Subscriber ID:
Insurance Co.	
Group #	Phone

AUTHORIZATION

I understand and agree that I am financially responsible for all charges, whether or not paid by insurance. I also agree that I am responsible if my account is placed for collections, which includes but is not limited to interest charges and attorney's fees.
I certify that the information that I have provided on both sides of this form is true and correct to the best of my knowledge.
I agree to inform Dr. Telthorst of any changes in my health status or the above information.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

Dental & Medical History

REASON FOR THIS VISIT

WHAT DO YOU EXPECT TO HAVE DONE TODAY?

YOU USUALLY SEE A DENTIST: ☐ AT LEAST TWO VISITS A YEAR ☐ ABOUT ONCE EVERY 2 OR 3 YEARS
☐ AT LEAST ONCE A YEAR ☐ ONLY WHEN I HAVE A PROBLEM

TELL US ABOUT YOUR LAST DENTIST:

DATE OF LAST VISIT_____ WHAT WAS DONE THEN?_____

WHY DID YOU LEAVE?_____

WHAT DID YOU LIKE BEST?_____

WHAT DID YOU LIKE LEAST?_____

HOW OFTEN DO YOU BRUSH? FLOSS? DO YOUR GUMS EVER BLEED?

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH?

IF YOU COULD CHANGE ANYTHING
ABOUT YOUR TEETH, WHAT WOULD IT BE?

DO YOU HAVE OR HAVE YOU EVER HAD:

- ☐ BAD BREATH
- ☐ FOOD IMPACTION
- ☐ SWELLING IN MOUTH
- ☐ UNPLEASANT TASTE
- ☐ AVOID BRUSHING ANY AREA OF YOUR MOUTH
- ☐ CLENCHING OR GRINDING OF TEETH
- ☐ COMPLICATIONS FROM EXTRACTIONS
- ☐ FEVER BLISTERS OR COLD SORES

- ☐ DIABETES
- ☐ EPILEPSY
- ☐ ARTHRITIS
- ☐ AIDS
- ☐ CANCER
- ☐ ASTHMA
- ☐ GLAUCOMA
- ☐ TUBERCULOSIS
- ☐ HEART TROUBLE
- ☐ RHEUMATIC FEVER
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART MURMUR
- ☐ KIDNEY DISORDER
- ☐ PSYCHIATRIC CARE
- ☐ ABNORMAL BLEEDING
- ☐ VENEREAL DISEASE
- ☐ HEPATITIS OR LIVER DISORDER
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS / HIPS

WOMEN:
- ☐ ARE YOU PREGNANT
- ☐ ARE YOU NURSING
- ☐ ARE YOU USING BIRTH CONTROL PILLS

WHAT IS YOUR HEIGHT?	WEIGHT?	DO YOU SMOKE? HOW MUCH?

LIST YOUR CURRENT MEDICATIONS:

ARE YOU ALLERGIC TO ANYTHING?

ANY OTHER PHYSICAL CONDITIONS
OF WHICH THE DOCTOR SHOULD BE AWARE?

DO YOU WISH TO SPEAK TO THE DOCTOR PRIVATELY ABOUT ANY PROBLEM? YES - NO

NAME OF YOUR PHYSICIAN PHONE

(Please Complete Both Sides of This Form)

Dental & Medical History