Patient Registration and Insurance Information

DAVIDSON PERIODONTICS

PATIENT INFORMATION

Name: _____
Age: _____ Date of Birth: _____ SS#: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell Phone #: _____
Employer: _____
Occupation: _____ Work Phone #: _____

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber Name: _____
Member ID#: _____ Subscriber Date of Birth: _____
Employer: _____
Dental Insurance Name: _____
Insurance Address: _____
Insurance Phone #: _____ Group #: _____

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber Name: _____
Member ID#: _____ Subscriber Date of Birth: _____
Employer: _____
Dental Insurance Name: _____
Insurance Address: _____
Insurance Phone #: _____ Group #: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to the named provider of the group insurance benefits otherwise payable to me.

Patient's Signature: _____ Date: _____

RELEASE OF INFORMATION

I authorize the release of information necessary to process the claim.

Patient's Signature: _____ Date: _____

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Patient Medical History

Patient Name: _____
Date of Birth: _____
Referring Doctor and Location: _____
Emergency Contact (Name, Relationship, Number):
_____
_____

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Indicate which of the following conditions you currently have or have had in the past. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Anemia
- ☐ Atrial Fibrilation
- ☐ Bell's Palsy
- ☐ Blood Disease
- ☐ Connective Tissue Disorder
- ☐ Cognitive Disability
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Easily Winded
- ☐ HIV
- ☐ Heart Attack, Date: _____
- ☐ Heart Surgery, Date: _____
- ☐ Headaches/Migraines
- ☐ Intellectual Disability
- ☐ Mental Disorders
- ☐ Osteoporosis Medication History
- ☐ Parkinson's Disease
- ☐ Respiratory Problems
- ☐ Raynaud's Syndrome
- ☐ Stomach Problems
- ☐ Sexually Transmitted Disease
- ☐ Tumors
- ☐ Vision Problems
- ☐ Anxiety
- ☐ Auto Immune Disease
- ☐ High Blood Pressure
- ☐ Chemotherapy
- ☐ Claustrophobia
- ☐ High Cholesterol
- ☐ CPAP User
- ☐ Emphysema
- ☐ Fainting Spells
- ☐ Heart Disease
- ☐ Hay Fever
- ☐ Hepatitis
- ☐ Immunosuppressed
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Currently/Possibly Pregnant or Nursing
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Strong Gag Reflex
- ☐ Substance Use
- ☐ Thyroid Disease
- ☐ Vertigo
- ☐ Aspiration/Choking Risk
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Chest Pain
- ☐ Cannabis/CBD Use
- ☐ COPD
- ☐ Dental Phobia
- ☐ Epilespy
- ☐ Glaucoma
- ☐ Heart Valve Replacement, Date: _____
- ☐ Head and Neck Injuries
- ☐ Immune Deficiency
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Therapy
- ☐ Restless Leg Syndrome
- ☐ Sjogren's Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers

☐ Diabetes
Latest A1C reading: _____ Date: _____

☐ Nicotine Use (circle all that apply):
Current Smoker Former Smokeless Tobacco Vaping

☐ Joint Replacement
Type: _____ Date: _____

☐ Cancer or History of Cancer
Type: _____

☐ **Please check this box if you have no medical conditions or concerns**

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Patient Medical History Continued

Please explain/clarify any conditions or alerts previously selected:

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Conditions/Alerts: (If none, please write none or N/A)

_____

_____

_____

Allergies (Please list all): (If none, please write none or N/A)

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain below:

_____

Name of your primary Physician and Phone Number:

_____

_____

Preferred Pharmacy and Phone Number:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

_____

_____

Are you currently taking any medications (prescription or non-prescription) including regular doses of aspirin? If yes, please list all medications and reason for being prescribed:

_____

_____

_____

_____

_____

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my signature.**

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Dental History

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What is your immediate concern or reason for referral?

_____

_____

Referring Dentist's Name and Phone Number:

_____

Date of most recent dental exam, dental cleaning, deep cleaning, or dental x-rays:

_____

_____

Check all that apply:

- ☐ Complications from past dental treatment
- ☐ Excessive bleeding
- ☐ Difficulty with anesthesia either getting or staying numb
- ☐ Adverse reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ Dry Mouth (Xerostomia)
- ☐ Experience teeth sensitive to cold, hot, biting, sweets, or brushing
- ☐ Food becomes trapped between teeth
- ☐ Jaw joint problems (pain, popping, clicking)
- ☐ Frequent headaches
- ☐ Sores or lumps in your mouth
- ☐ Head, neck or jaw injuries
- ☐ Difficulty chewing
- ☐ Clenching or grinding of your teeth
- ☐ Currently wear or have worn a bite guard appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Receding gums
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ Experience snoring, sleep apnea, insomnia, trouble falling asleep
- ☐ Have had scaling and root planing (deep cleaning)
- ☐ None

If any of the checked boxes need further explanation, please describe:

_____

_____

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Patient Privacy and Contact Information

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I wish to be contacted in the following manner (CHECK ALL THAT APPLY):

Home Phone #: _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number ONLY

Cell Phone #: _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number ONLY

Work Phone #: _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number ONLY

E-mail address: _____

My information may be released to:

General Dentist(s)/Dental Specialist(s): _____

Medical Doctor(s): _____

Other:	Relationship:
_____	_____
_____	_____
_____	_____

I confirm that the above information is correct and I have received the Notice of Privacy Practices.

Patient's Name (PRINT): _____

Patient's Signature: _____ Date: _____

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