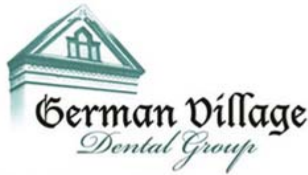

PATIENT REGISTRATION

First Name: ______________________
Last Name: ______________________
Middle Initial: ______________________
Preferred Name: ______________________
Birth Date: ______________________
Social Security: ______________________
O I would like to receive correspondences via email.

Address: ______________________
Address 2: ______________________
City, State Zip ______________________
Home Phone: ______________________
Work Phone: ______________________
Mobile Phone: ______________________
Email: ______________________

Gender:	O Male	O Female			
Patient Is:	O Policy Holder	O Responsible Party			
Marital Status	O Single	O Married	O Separated	O Divorced	O Widowed
Employment:	O Full-time	O Part-time	O Retired		
Student Status:	O Full-time	O Part-time			

Emergency Contact Information

First Name: ______________________
Last Name: ______________________

Main Phone: ______________________
Other Phone: ______________________

Responsible Party

First Name: ______________________
Last Name: ______________________
Middle Initial: ______________________
Birth Date: ______________________
Social Security: ______________________
Driver's License: ______________________

Address: ______________________
Address 2: ______________________
City, State Zip ______________________
Home Phone: ______________________
Work Phone: ______________________
Mobile Phone: ______________________

O Also a Policy Holder for Patient O Primary Insurance Policy Holder O Secondary Insurance Policy Holder

Primary Insurance Information

Relationship to Insured: O Self O Spouse O Child O Other

Insured: ______________________
Insured Social: ______________________
Insured DOB: ______________________

Insured Employer:

Name: ______________________
Address: ______________________
Address 2: ______________________
City, State, Zip: ______________________
Insurance Name ______________________

Secondary Insurance Information

Insurance Name

Relationship to Insured: O Self O Spouse O Child O Other

Insured Name: ______________________
Insured Social: ______________________
Insured DOB: ______________________

Insured Employer:

Name: ______________________
Address: ______________________
Address 2: ______________________
City, State, Zip: ______________________
Insurance Name ______________________

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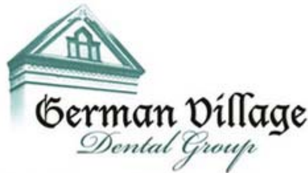

MEDICAL HISTORY

PATIENT NAME ______________________________ **BIRTH DATE** ______________________

Primary Care Physician's Name ______________________
Primary Care Physician's Phone: ______________________
Date of Last Medical Exam: ______________________

Are you currently under the care of a physician for a specific condition?	☐ YES	☐ NO
Have you been hospitalized in the past 5 years for a serious illness or operation?	☐ YES	☐ NO
Do you use tobacco (smoking or chewing)?	☐ YES	☐ NO
Are you pregnant or trying to become pregnant?	☐ YES	☐ NO
Are you currently taking any prescription or non-prescription medications?	☐ YES	☐ NO

If yes, please list all medications:

Please indicate if you have experienced any of the following conditions:

☐ Allergies/Hay Fever	☐ Heart Disease	☐ Radiation Treatment
☐ Anemia	☐ Hepatitis (A B C)	☐ Respiratory Problems
☐ Asthma	☐ High or Low Blood Pressure	☐ Rheumatic/Scarlet Fever
☐ Blood Disorders	☐ HIV+/AIDS	☐ Rheumatism/Arthritis
☐ Diabetes(Type I or Type II)	☐ Jaundice	☐ Sinus Problems
☐ Excessive Bleeding	☐ Joint Replacement (artificial joints)	☐ Ulcers/Gastric Reflux
☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Stroke
☐ Fainting or Dizziness	☐ Liver Disease	☐ Tuberculosis
☐ Headaches	☐ Mental Disorders	☐ Tumors/Cancer
☐ Head Injuries	☐ Mitral Valve Prolapse	☐ Other (please list below)
		______________________

Please check if you are allergic to the following:

☐ Aspirin	☐ Acetaminophen	☐ Clindamycin
☐ Codeine	☐ Latex	☐ Penicillin
☐ Sulfa	☐ Other ______________________	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

______________________ ______________________
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

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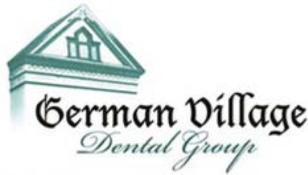


Nicole K. Munz, DDS - General Dentist

DENTAL HISTORY

PATIENT NAME ______________________________ **BIRTH DATE** ____________________

Are you currently experiencing any dental discomfort? ☐ YES ☐ NO

If YES, please explain ______________________________

Previous Dentist's Name ______________________________

Date of last dental cleaning ______________________________

Please check YES or NO if you have had problems with any of the following and location when indicated:

Bad Breath	☐ YES	☐ NO				
Clicking or popping jaw	☐ YES	☐ NO				
Previous orthodontic treatment	☐ YES	☐ NO				
Grinding or clenching	☐ YES	☐ NO				
Bleeding during brushing/flossing	☐ YES	☐ NO				
Periodontal treatment	☐ YES	☐ NO				
Wears partials or dentures	☐ YES	☐ NO	☐ TOP	☐ BOTTOM		
Sensitivity to cold	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT
Sensitivity to hot	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT
Sensitivity when biting	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT
Sensitivity to sweets	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT
Loose teeth or broken fillings	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT
Sores or lumps in mouth	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT

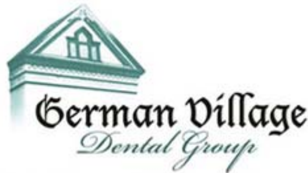
Is there anything you would like to change to enhance your smile? ☐ YES ☐ NO

If YES, please explain

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

______________________________ ____________________

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE



OFFICE POLICIES

As a courtesy to other patients, there is a 24-hour notice of cancellation required. The first time a patient fails to give adequate notice, a reminder will be given. However, after the second offense a $50.00 fee per half-hour may be charged.

This $50.00 per half-hour fee also applies to "no show" appointments. Multiple "no show" and "broken" appointments may result in patient dismissal.

Please be aware that there is a returned check fee of $40.00 and multiple offenses may result in a cash payment only.

Unpaid account balances will incur a service charge of 1.5% per month after 60 days regardless of any insurance involvement.

Balances of 90 days or more, unless on a payment plan or other special arrangement, will be dealt with through legal action or collection agency of it becomes necessary. Should the collection action become necessary, all fees associated with collection costs are the financial responsibility of the account Responsible Party, thus increasing the total balance due.

Recurrent failure to comply with special financial agreements can result in legal action or postponement of future appointments until a resolution is made and all debt is satisfied. Signed financial agreements are legally binding.

For appointments requiring an extended length of time, the patient may be asked to secure the reserved time with their provider of care with a prepayment. We reserve the right to hold prepaid visits as non-refundable.

We will make every reasonable effort to help with insurance involvement, but please understand that insurance company policies are arrangements between the insurance company and the patient. The dentist is a third party and cannot be responsible for all debt occurring with the dentist regardless of the amount, if any, the insurance company decides to pay.

____ __________________________

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