Patient Registration

Please complete the following confidential information

Start Here for YOU

Date			
Last Name			First
Prefers to be called by			
Address			
City		State	Zip Code
Home No:		Work No:	
Cell No:		E-mail:	
Male	Female		
Married	Single	Divorced	Widowed
Birthday		Age	
Social Security No.			

Start Here for CHILD

Date			
Last Name			First
Prefers to be called by			
Address			
City		State	Zip Code
Home No.		Addtl No.	
Cell No:			
Male	Female	School	
Birthday		Age	Grade
Social Security No.			

Primary Dental Insurance
Insurance Company:
Ins Co. Address
City, State Zip
Group No. / I.D. No.
Ins. Co. Phone Number
Employer Name
Subcriber's Name
Social Security No.
Date of Birth:
Relationship to Patient: *Self Spouse Child Other*

Patient Information **(If not the responsible party)**		
Name		
Relationship to Patient		
Address		
City	State	Zip
Home No	Cell No.	
Employer		
Address:		
Work No.		

Person Financially Responsible for Account		
Name		
Relationship to Patient		
Address		
City	State	Zip
Home No.	Cell No.	
E-mail Address:		
Employer		
Address		
Work No.		

Person to contact for Emergency		
Name:		
Realtionship		
Address		
City	State	Zip
Home No.		
Cell No.		
Work No.		

Getting To Know You
Is another family member at patient?
Name:
Relationship:
How were you Referred to our office?

Dental History

PATIENT NAME: DATE:

What is the reason for your visit today? _____

Previous Dentist Name _____

Address _____ *State* _____ *Zip* _____

Telephone _____ *Fax* _____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

How often do you have dental examinations? ❑ Every 6 months ❑ Once a year ❑ Other _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (electric toothbrush, toothpick, etc) _____

Do you have any dental problems now? *Yes No If yes, describe:* _____

	Are any of your teeth sensitive to:		**Have you ever had:**
❑	Hot or Cold	❑	Orthodontic treatment
❑	Sweets	❑	Oral Surgery
❑	Biting or Chewing	❑	Periodontal treatment
❑	Any mouth odors or bad tastes?	❑	Your bite adjusted
❑	Frequently get cold sores, blisters or any other lesions?	❑	A mouth guard or bite plate
❑	Gums bleed or hurt?	❑	A serious injury to the mouth or head?
Y / N	Have your parents experienced gum disease or tooth loss?		*If so, please describe:*
Y / N	Have you noticed any loose teeth or change in your bite?		**Have you experienced:**
Y / N	Does food tend to become caught between your teeth?	❑	Clicking or popping of the jaw
	If yes, where?	❑	Pain (joint, ear, side of face)
		❑	Difficulty in opening or closing the mouth
	Do You:	❑	Difficulty in chewing on either side of the mouth
❑	Clench or grind your teeth while awake or asleep?	❑	Headaches, neck aches or shoulder aches
❑	Bite your lips or cheeks regularly?	❑	Sore muscles (neck, shoulder)
❑	Hold foreign objects with your teeth?		
❑	Mouth breathe while asleep or awake?		**Are you satisfied with your teeth's appearance?**
❑	Have tired jaws, especially in the morning?	Y / N	Would you like to keep all of your teeth all your life?
❑	Smoke / chew tobacco or use other tobacco products?	Y / N	Do you feel nervous about having dental treatment?
❑	Snore, been told you snore, or have any sleeping disorders?		*If yes, what is your biggest concern?*

Have you ever had an upsetting dental experience? If yes, please describe: _____

_____

Is there anything else about having dental treatment that you would like us to know? _____

_____

Medical Form

PATIENT NAME: DATE :

If you answered ***yes*** please explain:

Are you under a physician's care now?	❑ Yes	❑ No	_____
Have you ever been hospitalized or had a major operation?	❑ Yes	❑ No	_____
Have you ever had a serious head or neck injury?	❑ Yes	❑ No	_____
Are you taking any medications, pills or drugs?	❑ Yes	❑ No	_____
			_____
Have you been diagnosed with a sleep disorder or apnea?	❑ Yes	❑ No	_____
Do you take, or have you taken, Phen-Fen or Redux?	❑ Yes	❑ No	_____
Are you on a special diet?	❑ Yes	❑ No	_____
Do you use tobacco?	❑ Yes	❑ No	_____
Do you use controlled substances?	❑ Yes	❑ No	_____

Women: Are you ❑ Pregnant / trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑Aspirin ❑Penicillin ❑Codeine ❑Acrylic ❑Metal ❑Latex ❑ Local Anesthetics ❑Other _____

Do you have, or have you had any of the following?

❑	AIDS/HIV positive	❑	Chest pains	❑	Frequent Headaches	❑	Irregular Heart Beat	❑	Scarlet Fever
❑	Alzheimer's Disease	❑	Cold Sores/Fever Blisters	❑	Genital Herpes	❑	Kidney Problems	❑	Shingles
❑	Anaphylaxis	❑	Congenital Heart Disease	❑	Glaucoma	❑	Leukemia	❑	Sickle Cell Disease
❑	Anemia	❑	Convulsions	❑	Hay Fever	❑	Liver Disease	❑	Sinus Trouble
❑	Angina	❑	Cortisone Medicine	❑	Heat Attack/Failure	❑	Low Blood Pressure	❑	Spina Bifida
❑	Arthritis/Gout	❑	Diabetes	❑	Heart Murmur*	❑	Lung Disease	❑	Stomach/Intestinal Disease
❑	Artificial Heart Valve	❑	Drug Addiction	❑	Heart Pace Maker*	❑	Mitral Valve Prolapse*	❑	Stroke
❑	Artificial Joint	❑	Easily Winded	❑	Heart Trouble/Disease	❑	Pain in Jaw Joints	❑	Swelling of Limbs
❑	Asthma	❑	Emphysema	❑	Hemophilia	❑	Parathyroid Disease	❑	Thyroid Disease
❑	Blood Disease	❑	Epilepsy or Seizures	❑	Hepatitis A	❑	Psychiatric Care	❑	Tonsillitis
❑	Blood Transfusion	❑	Excessive Bleeding	❑	Hepatitis B or C	❑	Radiation Treatments	❑	Tuberculosis
❑	Breathing Problem	❑	Excessive Thirst	❑	Herpes	❑	Recent Weight Loss	❑	Tumors or Growths
❑	Bruise Easily	❑	Fainting or Dizzy Spells	❑	High Blood Pressure	❑	Renal Dialysis	❑	Ulcers
❑	Cancer	❑	Frequent Cough	❑	Hives or Rash	❑	Rheumatic Fever*	❑	Venereal Disease
❑	Chemotherapy	❑	Frequent Diarrhea	❑	Hypoglycemia	❑	Rheumatism	❑	Yellow Jaundice

** Condition may require medication*

Have you ever had any serious illness not listed above? ❑ 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 Today's Date

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental and/or medical needs.
   (Name of Patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give my consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½ % late charges (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

6. I give my permission for my or my dependents diagnostic and treatment records to be used for purposes of research, education, or publication in professional journals.

_____ / _____ _____

Patient's or Guardian's Signature *Relationship to Patient* *Today's Date*

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RULES

I, _____, have received and/or reviewed a copy of the
(Patient's Name)
Notice of the Privacy Practices for the office of ***Sherman Oaks Dental & Dental Sleep Medicine of Illinois.***

Please sign and date: _____Date:_____
(parent signature if a minor)

OPTING OUT:

☐ I **do not** want appointment reminder messages left on my home answering system; I understand that the office may charge me should I fail to keep my appointment.

☐ I **do not** want appointment reminder messages left at my place of employment; I understand that the office may charge me should I fail to keep my appointment.

☐ I **do not** want appointment reminders by e-mail.

☐ I **do not** wish my protected health care information to be released to the following persons _____ .
(give name and address)

☐ I **decline** to sign the Acknowledgement.

OFFICE USE:

The office was unable to obtain a signed Acknowledgement form from the above patient for the following reasons:

SUPPLEMENTARY HEALTH QUESTIONNAIRE

Patient Name: _____Today's Date: _____

Have there been any changes in your medical history since your last visit? Yes _____ No _____

Has anyone ever commented or told you that you snore? Yes _____ No _____
If yes, how often: rarely _____ sometimes _____ often _____ most nights _____

Has anyone ever heard you stop breathing or choking at night? Yes _____ No _____

On an energy level, 10 being the most active and energetic. How would you rate yourself on most days?
(Circle one) 1…..2…..3…..4…..5…..6…..7…..8…..9…..10

Have you been diagnosed with a sleep disorder? Yes _____ No _____
*If yes, h*ave you been prescribed CPAP therapy? Yes _____ No _____
If yes, do you wear your CPAP and how often?
every night_____ most nights_____ couple nights per week _____ never_____

Do you experience headaches or migraines regularly? Yes _____ No _____
If yes, how often: rarely _____ sometimes _____ often _____
What medications to you take? _____

Do you knowingly grind your teeth at night or have been told by a dentist that you may be grinding?
If yes, do you wear a night guard? Yes _____ No _____
Have you ever had a problem with your TMJ /TMD jaw joint? Yes _____ No _____

Are you happy with the appearance of your teeth? Yes _____ No _____
If no, are you dissatisfied with: *(circle all that apply)*

Color _____ Looks of previous fillings / crowns _____
Shape _____ Condition / Level of gums _____
Spacing _____ Other _____
Crowding ____

Are you interested in knowing more about our home whitening system? Yes _____ No _____

Have you noticed a bad taste/odor in your mouth on a frequent basis? Yes _____ No _____

Are you regularly involved in sports? Yes _____ No _____
List sports? _____

Would you like to know more about our custom athletic sports guards for you or a family member?
Yes _____ No _____

Are you interested in knowing about permanent tooth replacement? Yes _____ No _____
or implant tooth replacement? Yes _____ No _____