MONARCH VIEW DENTAL CARE

PATIENT REGISTRATION

Date: _____

Patient Information

Last Name: _____ First Name: _____ M.I.: _____

Prefers to be called by: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Birthday: _____ Age: _____ Gender: Male ☐ Female ☐

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Social Security Number: _____

*Is this appointment for your child? Yes ☐ No ☐

If your child's last name and/or address are not the same as yours, please fill in the fields below.

Referred By: _____

Patient Parent Information

**Skip these fields if the appointment is for you.*

Last Name: _____ First Name: _____ M.I.: _____

Prefers to be called by: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: : _____

Birthday: _____ Age: : _____ Gender: Male ☐ Female ☐

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Social Security Number: _____

Insurance Information

Primary Carrier

Insurance Company: _____

Group Number: _____

Employer Name: _____

Insured's Name: _____

Date of Birth: _____

Relationship to Patient: _____

Insured's I.D. Number: _____

Insured's Social Security Number: _____

Secondary Carrier

Insurance Company: _____

Group Number: _____

Employer Name: _____

Insured's Name: _____

Date of Birth: _____

Relationship to Patient: _____

Insured's I.D. Number: _____

Insured's Social Security Number: _____

MONARCH VIEW
DENTAL CARE

Getting To Know You

Is another member of your family or relative a patient at our office? Yes ☐ No ☐

Name: _____ Relationship: _____

Emergency Contact Name: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Account Information

Person Financially Responsible For Account

Name: _____ Relationship to Patient: _____

Phone: _____ Social Security Number: _____

Employment

Name: _____ Occupation: _____

Employer's Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Spouse's Employment

Name: _____ Occupation: _____

Employer's Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

MONARCH VIEW
DENTAL CARE

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 (name of patient) _____'s dental needs.

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 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 service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature: _____ Date: _____

Witness: _____

Parent/Responsible Party's Signature: _____

Relationship to Patient: _____

MONARCH VIEW DENTAL CARE

DENTAL HISTORY

Patient Name: _____ Patient Account No: _____ Medical Alert: _____

Welcome! So that we may provide you with the best possible care, please complete all fields of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Last Dental Visit: _____ **Last Dental Cleaning:** _____ **Last Full Mouth X-Rays:** _____

What was done at your last dental visit? _____

Previous Dentist's Name: _____ Phone: _____

Address: _____ State: _____ Zip: _____

How often do you have dental examinations? _____

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

Have you ever used or are currently using topical fluoride? Yes ☐ No ☐

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

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

Are any of your teeth sensitive to:

Hot or cold?	Yes ☐ No ☐
Sweets?	Yes ☐ No ☐
Biting or Chewing?	Yes ☐ No ☐
Have you noticed any mouth odors or bad tastes?	Yes ☐ No ☐
Frequently get cold sores, blisters or other oral lesions?	Yes ☐ No ☐
Do your gums bleed or hurt?	Yes ☐ No ☐
Have your parents experienced gum disease or tooth loss?	Yes ☐ No ☐
Noticed any loose teeth or change in your bite?	Yes ☐ No ☐
Does food tend to get caught in between your teeth?	Yes ☐ No ☐

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes ☐ No ☐
Bite your lips or cheeks regularly?	Yes ☐ No ☐
Hold foreign objects with your teeth? (pencils, pipe…)	Yes ☐ No ☐
Mouth breathe while awake or asleep?	Yes ☐ No ☐
Have tired jaws, especially in the morning?	Yes ☐ No ☐
Snore or have any other sleeping disorders?	Yes ☐ No ☐
Smoke/chew tobacco or use other tobacco products?	Yes ☐ No ☐

Have you ever had?

Orthodontic treatment?	Yes ☐ No ☐
Oral Surgery?	Yes ☐ No ☐
Periodontal treatment?	Yes ☐ No ☐
Your teeth ground or the bite adjusted?	Yes ☐ No ☐
A bite plate or mouth guard?	Yes ☐ No ☐
A serious injury to the mouth or head?	Yes ☐ No ☐

If yes please describe, including cause: _____

_____

Have you ever experienced?

Clicking or popping of the jaw?	Yes ☐ No ☐
Pain? (joint, ear, side of face)	Yes ☐ No ☐
Difficulty in opening or closing of the mouth?	Yes ☐ No ☐
Difficulty in chewing on either side of the mouth?	Yes ☐ No ☐
Headaches, neckaches or shoulder aches?	Yes ☐ No ☐
Sore muscles (neck, shoulders)?	Yes ☐ No ☐

Satisfied with your teeth's appearance? Yes ☐ No ☐

Would you like to replace your silver fillings?	Yes ☐ No ☐
Would you like to keep all of your teeth all of your life?	Yes ☐ No ☐

Do you feel nervous about having dental treatment? Yes ☐ No ☐

Please describe: _____

Have you ever had an upsetting dental experience? Yes ☐ No ☐

Please describe: _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes ☐ No ☐

Is there anything else about having dental treatment that you would like us to know? Yes ☐ No ☐

If yes, please describe: _____

MONARCH VIEW DENTAL CARE

MEDICAL HISTORY

Patient Name: _____ Patient Account No: _____ Medical Alert: _____

1. Physician's Name: _____ Phone: _____

Have you had any medical care within the past two years? Yes ☐ No ☐

Describe: _____

2. Have you taken any medication or drugs during the past two years? Yes ☐ No ☐

If yes, please list name and dosage: _____

3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Yes ☐ No ☐

If yes, please list name and dosage: _____

4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? Yes ☐ No ☐

If yes, please list name and dosage: _____

5. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? Yes ☐ No ☐

If yes, please specify? _____

6. Have you been a patient in the hospital during the past five years? Yes ☐ No ☐

7. Indicate which of the following you have had, or have at present.

Heart (Surgery, Disease, Attack)	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐	Hepatitis A B C (circle)	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐
Congenital Heart Disease	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐	AIDS, HIV Positive	Yes ☐ No ☐
Heart Murmur	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Cold Sores/Fever Blisters	Yes ☐ No ☐
High/Low Blood Pressure	Yes ☐ No ☐	Contact Lenses	Yes ☐ No ☐	Blood Transfusion	Yes ☐ No ☐
Mitral Valve Pressure	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐
Artificial Heart Valve/Pacemaker	Yes ☐ No ☐	Chronic Cough	Yes ☐ No ☐	Sickle Cell Disease	Yes ☐ No ☐
Rheumatic Fever	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐	Bruise Easily	Yes ☐ No ☐
Arthritis/Rheumatism	Yes ☐ No ☐	Asthma	Yes ☐ No ☐	Liver Disease/Yellow Jaundice	Yes ☐ No ☐
Cortisone Medicine	Yes ☐ No ☐	Hay Fever/Allergy/Hives	Yes ☐ No ☐	Neurological Disorders	Yes ☐ No ☐
Swollen Ankles	Yes ☐ No ☐	Latex Sensitivity	Yes ☐ No ☐	Epilepsy or Seizures	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Sinus Trouble	Yes ☐ No ☐	Fainting or Dizzy Spells	Yes ☐ No ☐
Diet (Special/Restricted)	Yes ☐ No ☐	Radiation Therapy	Yes ☐ No ☐	Nervous/Anxious	Yes ☐ No ☐
Artificial Joints (Hip, Knee etc)	Yes ☐ No ☐	Chemotherapy	Yes ☐ No ☐	Psychiatric/Psychological Care	Yes ☐ No ☐
Kidney Trouble	Yes ☐ No ☐	Tumors	Yes ☐ No ☐	Cancer	Yes ☐ No ☐

8. Have you lost or gained more than 10 pounds in the past year? _____

9. Do you have or have you had any disease, condition, or problem not listed? Yes ☐ No ☐

If yes, please list: _____

10. Women: Are you pregnant or think you could be pregnant? Yes ☐ Months: ____ No ☐ Nursing? Yes ☐ No ☐

11. Do you use birth control prescriptions? Yes ☐ No ☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: _____ Date: _____

History Review

_____

_____

_____

_____

_____

_____

_____

Dentist Signature: _____