Patient Registration Form

Thank you for selecting our dental health team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email:_____ Date of Birth: ____/____/_____ SS#: _____ - _____ - _____

Marital Status (Circle One): S M D W Gender (Circle One): M F

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Spouse's Name: _____ Date of Birth: _____

Person Responsible for the Account (If someone other than the patient): _____

SS#:_____-_____-_____ Date of Birth:____/____/_____ Relationship to patient_____

Employer Name and Address:_____

How did you hear about us? Internet____ Phone Book_____ Newspaper_____ Hospital_____

Patient_____ Other_____

Primary Dental Insurance Information:

Name of Insured: _____ Relationship: _____

Subscriber's Date of Birth: ____/_____/_____ Subscriber's SS#:_____-_____-_____

Dental Insurance Company: _____ Insurance Phone: (____) _____

Subscriber Number: _____ Group Number: _____

Employer Name: _____

Secondary Dental Coverage:

Do you have secondary dental insurance coverage? (Circle one) Yes No

If yes, please provide information on your coverage. We will be happy to file your secondary claim for you. However, you are responsible for all co-payments before your secondary insurance is filed. Your secondary insurance will be instructed to reimburse you directly.

Name of Insured: _____ Relationship: _____

Subscriber's Date of Birth ____/_____/_____ Subscriber's SS#:_____-_____-_____

Dental Insurance Company: _____ Insurance Phone: (____) _____

Subscriber Number: _____ Group Number: _____

Employer Name: _____

Insurance Co. Phone (_____) _____

Children under 16 must be accompanied by an adult (guardian). 16 to 18 year olds must have guardian's written consent for treatment.

I acknowledge that I am responsible for all insurance copayments on the day of service including services preformed that are not covered by my insurance provider. As a courtesy, Canon Family Dental will submit dental insurance claims and accepts no responsibility for the amount, length, or scope of my provider's coverage. Should situations arise concerning my dental coverage, I understand it is my responsibility to contact my insurance provider. In addition, I understand I am required to pay in full for all treatment performed at the time of service even if Canon Family Dental is not a preferred provider for my dental insurance. In this case, I understand that I will be directly reimbursed by my insurance provider. Insurance coverage estimates provided to me by Canon Family Dental are based on amounts reported by my insurance provider at the time coverage information was requested and are subject to change. Financial Responsibility: In the event that this bill is not paid in full and is subsequently assigned for collections, the consumer or entity signing below hereby agrees to pay collection costs for collection of accounts of $50 and is responsible for reasonable attorney fees. On all unpaid balances, interest will accrue at 1.5% per month. My signature below indicates I understand and agree to all the above.

Signature: _____ Date: _____

CAÑON FAMILY DENTAL

Patient Name: _____ **Date:** _____

Patient Medical and Dental History

Although dental personnel primarily treat dental conditions, your mouth is part of your entire body. Health problems you may have or medications you may be taking could have an effect on the dentistry you will receive.

Dental History:

Primary reason for this dental appointment: ☐ Exam ☐ Emergency ☐ Consultation
Do you have a specific dental problem? Please explain: _____
Do you think you have active decay or gum disease? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No
Do you like your smile? ☐ Yes ☐ No
Do you want to keep your remaining teeth? ☐ Yes ☐ No
Do have clicking, popping, or discomfort in the jaw joints? ☐ Yes ☐ No
Preferred Dentist: _____ Preferred Hygienist: _____

Medical History:

Are you under the care of a physician? ☐ Yes ☐ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Please list: _____
Have you received treatment for osteoporosis? ☐ Yes ☐ No If yes, please explain: _____
Do you use tobacco? ☐ Yes ☐ No If yes, (circle one): Smoke Chew

Are you allergic to any of the following?

☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local anesthetics

Other: (Please be specific) _____

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

☐ Angina	☐ Anemia	☐ Arthritis/Gout	☐ Chemotherapy
☐ Heart Attack	☐ Scarlet Fever	☐ Artificial Joint	☐ Radiation Treatments
☐ Heart Murmur	☐ Asthma	☐ Swelling of the Limbs	☐ Leukemia
☐ Mitral Valve Prolapse	☐ Easily Winded	☐ Cortisone Medication	☐ Liver Disease
☐ Congenital Heart Disorder	☐ Emphysema	☐ Ulcers	☐ Hepatitis A, B, or C
☐ Pace Maker	☐ Lung Disease	☐ Frequent Diarrhea	☐ Drug Addiction
☐ Chest Pain	☐ Tuberculosis	☐ Gastric Reflux Disease	☐ AIDS/HIV
☐ Irregular Heartbeat	☐ Hay Fever	☐ Recent Weight Loss	☐ Venereal Disease
☐ Artificial Heart Valve	☐ Sinus Trouble	☐ Eating Disorder	☐ Shingles
☐ High Blood Pressure	☐ Frequent Headaches	☐ Diabetes	☐ Psychiatric Care
☐ Low Blood Pressure	☐ Stroke	☐ Hypoglycemia	☐ Autism
☐ Excessive Bleeding	☐ Fainting Spells/Dizziness	☐ Excessive Thirst	☐ Down Syndrome
☐ Bruise Easily	☐ Epilepsy/Seizures	☐ Kidney Problems	☐ Special Needs (please specify):
☐ Rheumatic Fever	☐ Alzheimer's	☐ Renal Dialysis	
☐ Hemophilia	☐ Glaucoma	☐ Cancer	

Have you had any other serious illness not listed above? ☐ Yes ☐ No If yes, please list: _____
Emergency Contact: _____ Phone Number: (____) _____
Physician Name: _____ Phone Number: (____) _____

Women:

Are you: ☐ Pregnant ☐ Nursing ☐ Taking oral contraceptives?

To the best of my knowledge, I have accurately answered the questions on this form. I understand providing incorrect or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform Canon Family Dental of any changes in medical status in a timely manner.

Signature: _____ Date: _____