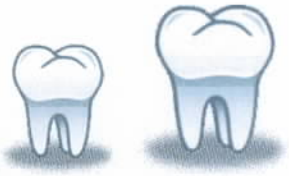
Newport Smiles Dental Spa Patient Registration



Patient's Name _____ SSN# _____
Date of Birth _____ [ ] Male [ ] Female
Address_____ City _____ State _____ Zip_____
Home Phone _____ Work Phone _____ Cell Phone _____
Email _____ Driver's License #_____ State_____
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed
Employer/School Name _____ Occupation _____
How did you hear about us? _____

Dental Insurance Information

Insurance Company Name _____ Phone _____
Subscriber ID _____ Group ID _____
Subscriber's Name _____ SSN#_____
Date of Birth _____Employer _____ Phone _____

Insurance and Financial Policy

Total payment is appreciated at the time of service. We accept Cash, Check, Visa, MasterCard, or Discover. We also offer 12 month interest free financing through Care Credit. We are in network with many PPO plans; however your insurance policy is a contract between you, your employer and the insurance company. We are not part of that contract except to accept the insurance company's fees. In the event we do not receive payment from your insurance company within 90 days of filing a claim with them, the balance will be your responsibility. You are ultimately responsible for any services not paid for by your insurance company. Your treatment plan is individually tailored to your dental needs and is not based on your dental insurance benefits and what they may or may not deem as necessary. In order to give you an estimate of cost for your needed dental treatment, we will verify your insurance benefits prior to treatment but they will only give us a basic breakdown of benefits. It is your responsibility to know your contract limitations. It is your responsibility to fully understand the coverage and exceptions of your particular policy.

Consent for Dental Treatment

I hereby give Dr. Renata Adames and Newport Smiles Dental Spa my consent for dental treatment. I have read and fully understand the above stated policies and I agree to abide by them. I grant permission to you or your assignee, to telephone me at any phone number above to discuss matters related to this form and to my dental treatment. By signing this form, I further authorize the release of information to my insurance provider.

Patient Signature _____ **Date** _____

DENTAL HISTORY

Reason for today's visit _____

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

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

What was done at your last dental visit? _____

Did any previous dentists recommend dental treatment that was never performed? ☐ Yes ☐ No

If yes, what type of work was it? _____ Why was this treatment never performed? _____

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

Ever had an upsetting dental experience? ☐ Yes ☐ No If so, please describe _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____ How often do you floss? _____

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

Please circle the following dental values most important to you and underline the least important:

Esthetics Comfort Longevity Function Long-term cost effectiveness

Please circle the most important feature(s) in your smile that you would like to change?

Color Shape Alignment Length Gaps Gum display Nothing, I'm happy. Other _____

Would you like your smile analyzed? ☐ Yes ☐ No If yes, is there a spouse or significant other you want to include in our discussion? ☐ Yes ☐ No

Are any of your teeth sensitive to:

- Hot or cold? ☐ Yes ☐ No
- Sweets? ☐ Yes ☐ No
- Biting or chewing? ☐ Yes ☐ No

Noticed any mouth odors or bad tastes? ☐ Yes ☐ No
Do you get cold sores, blisters or other oral lesions? ☐ Yes ☐ No
Do your gums bleed or hurt? ☐ Yes ☐ No
Have your parents had gum disease or tooth loss? ☐ Yes ☐ No
Noticed any loose teeth or change in your bite? ☐ Yes ☐ No
Does food tend to become caught between any teeth? ☐ Yes ☐ No
If yes, where _____

Do you:

- Clench/grind teeth while awake or asleep? ☐ Yes ☐ No
- Bite your lips or cheeks regularly? ☐ Yes ☐ No
- Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? ☐ Yes ☐ No
- Mouth breathe while awake or asleep? ☐ Yes ☐ No
- Have tired jaws, especially in the morning? ☐ Yes ☐ No
- Smoke/chew tobacco? ☐ Yes ☐ No

Have you ever had:

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

If so, please describe, including cause _____

Have you experienced:

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

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

If yes, please describe _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ 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? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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 _____