CR Smiles Dental Center Patient Registration Form

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

If This Appointment Is for YOU Start Here

Today's Date			
Last Name	First	M.I.	
Address			
City	State	Zip	
Home Phone No.	Cell No.		
Birthdate	Age	Male	Female
Married	Single	Divorced	Widowed
Social Security No.			
Email Address			

If This Appointment Is for YOUR Child Start Here

Today's Date			
Last Name	First	M.I.	
Prefers to be called by			
Address			
City	State	Zip	
Home Phone No.	Cell No.		
Birthdate	Age	Male	Female
School			Grade
Social Security No.			
If your child's name and/or address are not the same as yours, please fill in the top box as well.			

Patient Registration

Dental Insurance

PRIMARY DENTAL INSURANCE

Insurance Company	
Phone #	
Group/Policy #	
Employers Name	
Insured's Name	
D.O.B	Relationship to Patient
Insured's Social Security No.	

SECONDARY DENTAL CARRIER (If Any)

Insurance Company
Phone #
Group/Policy #
Employers Name
Insured's Name
D.O.B.
Insured's Social Security No.

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name		
Relationship to Patient		
Address (If Not Same As Patient)		
City	State	Zip
Phone No.		Ext.

YOUR

Occupation	Employer
Business Phone No.	Ext.
Where And When Are The Best Times To Reach You	

YOUR SPOUSE

Name	
Occupation	Employer
Business Phone No.	Ext.

Getting to Know You

Referred to Us By		
Person to Contact for Emergency		Relationship
Home Phone No.		Work Phone No.
City	State	Zip
Closest Relative Not Living With You		
Phone No.		
City	State	Zip

PLEASE TURN OVER AND SIGN

IN ORDER FOR US TO CONTINUE TO PROVIDE EXCELLENT DENTAL CARE AND PERSONALIZED SERVICE AT A REASONABLE COST WE ASK YOU TO READ THE FOLLOWING:

- We require a 24 hour cancellation notice or a $50 "No show" fee will be applied. We reserve time exclusively for you with the doctor, and we ask you to respect that time.
- For your convenience we accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover and American Express. There will be a fee for all returned checks.
- If you require a monthly payment plan, please ask us about our financing partners, Healthcare Credit and Care Credit. Our financial coordinator will be happy to assist you in reviewing all options available for your treatment.
- Accounts severely past due are subject to collection. All fees, including but not limited to, collection fees, attorney's fees, and court fees shall become your responsibility in addition to the balance due this office.

I hereby authorize my insurance benefits to be paid directly to CR Smiles Dental Center.
I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature____ 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 (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 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.

Signature____ Date____________

Parent/Responsible Party's Signature____________________ Relationship to Patient____________

CR SMILES
DENTAL CENTER

Name	Date of Birth

Health History Questionnaire (Confidential)

1. Have you had any health problems in the past five (5) years?.. ☐Yes ☐No
2. Have you seen a physician or other health care provider in the past two (2) years? .... ☐Yes ☐No
   Physician's name:____Phone # or City:__________________________
3. Is there any activity your doctor says you cannot do? .... ☐Yes ☐No
4. Have you been hospitalized or had a serious illness in the past five (5) years?... ☐Yes ☐No
5. Have you ever had a bleeding problem?... ☐Yes ☐No

BASELINE VITAL SIGNS	Temp	Pulse	Date	B.P.				
				Date				

Please circle the appropriate response if you have ever had the following. If you are not sure, do not answer questions.

HEART/BLOOD VESSELS

Rheumatic fever .... Yes No
Rheumatic heart disease............. Yes No
Heart valve damage.......................... Yes No
Heart murmur.................................. Yes No
Congenital heart defect .... Yes No
Artificial heart valve .... Yes No
Prolapsed heart valve .... Yes No
High blood pressure .... Yes No
Heart attack (Date_____) .... Yes No
TIA stroke (Date_____) .... Yes No
Heart Surgery (Date_____).............. Yes No
Vascualar Surgery (Date_____)........ Yes No
Pacemaker.. Yes No
Coronary heart failure .... Yes No
Congestive heart failure .... Yes No
Angina pectoris/chest pain .... Yes No
Irregular/rapid heart beats .... Yes No
Other heart or vessel disorder........... Yes No

BLOOD

Blood clots or thrombosis .... Yes No
Anemia.. Yes No
Sickle cell disease / trait................... Yes No
Hemophilia....................................... Yes No
Transfusion (Date_____) .... Yes No
Bruise easily for no
apparent reason .... Yes No
Other blood disorder .... Yes No

NERVOUS SYSTEM

Epilepsy .... Yes No
Seizure disorder .... Yes No
Multiple sclerosis ... . Yes No
Trigeminal neuralgia........................ Yes No
Chronic pain..................................... Yes No
Anxiety/depression........................... Yes No
Alzheimer's disease/dementia .... Yes No
Psychiatric treatment........................ Yes No
Psychological counseling................. Yes No
Persistent dizziness/fainting
spells .... Yes No
Persistent numbness/tingling............ Yes No
Other nervous system/mental
disorder .... Yes No

HEAD AND NECK

Glaucoma .... Yes No
Chronic sinusitis .... Yes No
Injury to head, neck, jaw
or teeth... Yes No
Headaches.. Yes No
Unexplained visual change.................... Yes No
Frequent or severe nosebleeds............... Yes No
Persistent sore throat
or hoarseness .... Yes No
Recurrent neckache
or neck pain .... Yes No
Recent difficulty swallowing................. Yes No
Other head or neck disorder................... Yes No

ENDOCRINE

Diabetes.. Yes No
Low thyroid..................................... Yes No
Other thyroid condition .... Yes No
Cushings syndrome .... Yes No
Parathyroid condition .... Yes No
Other endocrine condition .... Yes No

MUSCULOSKELETAL / CONNECTIVE TISSUE

Sjogren's syndrome .... Yes No
Arthritis .... Yes No
Artificial joint (Date______) .... Yes No
Fibromyalgia/rheumatism..................... Yes No
Chronic back pain.............................. Yes No
Other muscle or bone disorder............... Yes No

RESPIRATORY

Tuberculosis (TB)............................... Yes No
Asthma .... Yes No
Chronic bronchitis .... Yes No
Emphysema .... Yes No
Persistent cough................................. Yes No
Cough up bloody sputum...................... Yes No
Shortness of breath .... Yes No
Other respiratory disorder..................... Yes No

URINARY TRACT

Kidney disease................................... Yes No
Renal dialysis .... Yes No
Venereal disease .... Yes No
Sexually transmitted disease.................. Yes No
Other urinary disorder .... Yes No

DIGESTIVE SYSTEM

Hepatitis .... Yes No
Cirrhosis of the liver/liver
disease .... Yes No
Ulcers .... Yes No
Jaundice .... Yes No
Frequent heartburn or reflux .... Yes No
Frequent nausea/vomiting............... Yes No
Other digestive disorder.................. Yes No

CANCER HISTORY

Cancer .... Yes No
If yes, what type__________________
Leukemia .... Yes No
Benign tumors/growths .... Yes No
Type of treatment:
Surgery.................................. Yes No
Radiation therapy.................... Yes No
Chemotherapy......................... Yes No
Hormone therapy .... Yes No

ALLERGY HISTORY

Are you allergic to or have you ever had a bad reaction to any of the following?

Dental anesthetics .... Yes No
Penicillin .... Yes No
Sulfa drugs .... Yes No
Other antibiotics.............................. Yes No
Aspirin .... Yes No
Latex products................................. Yes No
Metals, including jewelry................ Yes No
Other allergy .... Yes No

FAMILY HISTORY

Has anyone in your family (grandparent, parent, sibling, child) ever had:

Diabetes .... Yes No
Heart disease .... Yes No
Depression or anxiety...................... Yes No
Tuberculosis Yes No
Any disorder that "runs in"
your family.............................. Yes No

PLEASE CONTINUE ON OTHER SIDE

CR SMILES DENTAL CENTER

Name	Date of Birth

Health History Questionnaire (continued)

Please circle "yes if you have ever had the following. If you are not sure, do not answer the question.

MISCELLANEOUS

- Lupus erythematosus........................ Yes No
- Organ transplant............................... Yes No
  - If yes, which organ?____________________
- Suppressed immune system .... Yes No
- Persistent fever................................. Yes No
- Taken steroid/prednisone .... Yes No
- Tested positive for HIV.................... Yes No
- Been diagnosed with AIDS .... Yes No
- Taken prescription diet pills............. Yes No
  - If yes, please check type:
  - ☐Pondium ☐Phen-fen
  - ☐Redux ☐Other______________

MISCELLANEOUS (CONTINTUED)

- Used tobacco products .... Yes No
  - If yes, what type?____________________
  - How much?__________How long?________
  - Still using tobacco? .... Yes No
  - Would you like to quit? .... Yes No
  - Quit on? (Date____________)
- Drink Alcoholic beverages............... Yes No
  - If yes, how much?____________________
- Use methamphetamine, amphetamines or "speed"........... Yes No
- Use intravenous drugs....................... Yes No
- Use cocaine or "crack"...................... Yes No

MISCELLANEOUS (CONTINTUED)

- Used any other recreational drug.....Yes No
- Are you a recovering alcholic or addict?................................ Yes No

WOMEN ONLY

- Are you pregnant or is there a possibility that you may be pregnant? .... Yes No
- Are you breast feeding?.................. Yes No
- Are you in or have you passed through menopause (change of life)?..... Yes No

Do you have any other conditions that you think we should know about? ☐Yes ☐No____________________________

____

Please circle all medications you are currently taking:

Heart	Blood thinners	Hormones	Antibiotics	Tranquilizers
Nitroglycerin	Blood pressure	Insulin/diabetic drugs	Antihistamine	Antidepressants
Digitalis	Oral contraceptive	Thyroid	Cyclosporine A	Pain
Aspirin (_____tabs/day)	Steroid/Cortisone	Nifedipine		

List any Medication names and dosages including over the counter, herbal, and nutritional supplements:

______________________________________ ______________________________________

Signature of Patient, Parent or Guardian Date Signature of Dentist Date

Health History Updates *[Required at least every six (6) months; more often as indicated]*

Date	Not Changes Below	Patient Signature	Dentist Signature