PATIENT REGISTRATION

ID: ________ Chart ID:

First Name: Last Name: Middle Initial:

Patient is: ☐ Policy Holder Preferred Name:

☐ Responsible Party

Responsible Party (If someone other than the patient)

First Name: ____________ Last Name: ____________ Middle Initial: ____

Address: ____________ Address 2: ____________

City, State, Zip: ____________ Pager: ____________

Home Phone: ________ Work Phone: ________ Ext: ________ Cellular: ________

Birth Date: ________ Soc Sec: ________ Drivers Lic: ________

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager: ________

Home Phone: ________ Work Phone: ________ Ext: Cellular: ________

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: ________ Age: ________ Soc. Sec: ________ Drivers Lic:

E-mail: ____________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: ________ Pref. Dentist:

Employer ID: Pref. Pharmacy: ________

Carrier ID: Pref. Hyg.:

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: ____________ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ____________ Ins. Company: ____________

Address: ____________ Address: ____________

Address 2: ____________ Address 2: ____________

City,State,Zip: ____________ City,State,Zip: ____________

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: ____________ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ____________ Ins. Company: ____________

Address: ____________ Address: ____________

Address 2: ____________ Address 2: ____________

City,State,Zip: ____________ City,State,Zip: ____________

Rem. Benefits: .00 Rem. Deduct: ________.00

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?

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
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 ____________

Dental History

Dentist: _Dr. Tang__ Patient: ____________________ DOB:_________ Date:_______________

What is the reason for your dental visit today?______________________________________

How do you feel about your smile?____

Date of your last dental exam:_______________ Date of last dental x-rays:__________________

(Note: Y-Yes, N-No, DK-Don't Know)	Y	N	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

____

Signature of Patient Date

____

Signature of Dentist Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Patient Name: ______________________________

Dental Record #: _____________________________

Date of Visit: __________________________________

My signature on this form acknowledges that I have received a copy of Garden Dental of Glastonbury LLC Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by DHA and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

_____________________________________ ____________________

Patient's Signature Date

_____________________________________ ____________________

Signature of Patient's Representative Date Date
if patient is unable to sign

TO BE COMPLETED BY DENTAL OFFICE IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the Notice of Privacy Practices?

Yes No

2. Briefly describe the efforts made to obtain the patient's acknowledgement of

receipt of the Notice and explain why the patient was not able or unwilling to

sign this form: ____

General Consent

Dentist: __Dr. Tang__ Patient: ____________________DOB:________Date:______________

Dentistry is not an exact science and reputable practitioners cannot properly guarantee results. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. A treatment plan is based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during examination, but were found during the course of treatment. For example, root canal treatment may be needed during routine restorative procedures. Any change in treatment plan may result in additional fees. Guarantees and assurances cannot be made by anyone regarding the dental treatment which you have requested and authorized. It is essential that you keep your appointments and cooperate in your treatment to help insure the best possible result. Please read the following and initial and sign where noted.

SERVICES THAT MAY BE PROVIDED INCLUDE THE FOLLOWING

1. FILLINGS

Care must be exercised in chewing on filled teeth, especially on large fillings and during the first 24 hours, to avoid breakage. A more extensive restorative procedure than originally diagnosed may be necessary, due to more decay than anticipated. Sensitivity can occur following a newly placed filling and will usually go away with time. (Initials________)

2. CROWNS, BRIDGES AND LAMINATES

These restorations involve permanent alteration of the tooth structure. It is not always possible to match the color of the natural teeth exactly with artificial teeth. Temporary restorations may come off easily. Care must be taken to insure that they are kept on until the permanent restorations are delivered. The final opportunity to make changes to the new crowns, bridges or laminates (including the shape, fit, size and color) will be before cementation. It is necessary to keep the appointment for permanent cementation. Excessive delays may allow for tooth movement, necessitating the remaking of the restoration and additional charges may be incurred. (Initials________)

3. DENTURES (FULL AND PARTIAL)

The wearing of dentures can be difficult. Sore spots, altered speech and difficulty in eating are common problems. Due to jaw ridge loss, retention of full dentures can be a problem. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later (this is not included in the denture fee). You are responsible to return for delivery of the dentures. Failure to do so may result in poorly fitting dentures and remakes will require additional charges. Failure to wear partial dentures every day will likely lead to tooth movement, resulting in a partial that no longer fits. (Initials________)

4. PERIODONTAL DISEASE

Periodontal disease affects the gums and bone which support the teeth. It is a serious, progressive infection, causing breakdown of the gums and bone and eventual loss of teeth. It is

best treated in its early stage. Treatment options may include gum surgery, extractions and replacements. Undertaking any dental procedure may have a future adverse effect on the periodontia. (Initials________)

5. ENDODONTIC TREATMENT (ROOT CANAL)

Although over 90% effective, there is no guarantee that root canal treatment will succeed and complications can occur from the treatment. Endodontic files and reamers are very fine instruments and can separate during use. Additional surgical procedures may be necessary following root canal treatment. Despite all efforts to save it, the tooth may still be lost.

(Initials________)

6. REMOVAL OF TEETH (EXTRACTIONS)

Teeth may need to be extracted for various reasons, such as non-restorability, lack of bone support, part of orthodontic treatment, impactions, etc. There are alternatives to the removal of treatable teeth and these options include root canal treatment, periodontal treatment and crowns. Removal of teeth does not always remove the infection, if present, and further treatment may be necessary. There are risks involved in having teeth removed, including, but not limited to pain, swelling, spread of infection, dry socket, loss of feeling in the teeth, lips, tongue and surrounding tissues (which is usually temporary, but in rare cases is permanent), sinus involvement and jaw fracture. If complications arise during or following treatment, referral to a specialist may be needed, requiring further treatment and additional cost. (Initials________)

7. DRUGS, MEDICATIONS, AND ANESTHETICS

Antibiotics, analgesics, natural supplements and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting and/ or anaphylactic shock. There are risks associated with injections of local anesthetics, including but not limited to injury of surrounding tissue and paresthesia (numbness) of teeth, lips and surrounding tissues. Though quite rare, this numbness can sometimes be permanent. Studies have shown that Bisphosphonate (ex. Fosomax) therapy for osteoporosis can compromise treatment results.

(Initials_________)

____

Signature of Patient Date

____

Signature of Dentist Date