Patient Registration and Health History

Thank you for completing the following information

Last	First	Middle	Preferred
Birth Date	Social Security #	Drivers License #	

Address

City	State	Zip Code	
Home Phone #	Business Phone #	Cell Phone #	E-mail

Would you like Email confirmations? __________

Accounts Responsible Person Information

(If person different from above. Please fill in completely)

Name of responsible party

Relationship to patient

Billing Address

City	State	Zip Code	
Birth Date	Social Security #	Drivers License #	

Employer: ____

Home Phone #	Business Phone #	Cell Phone #	E-mail

Dental Insurance Information

Primary Insurance	Employee ID/SS #	Group #	Telephone #

Address

City	State	Zip Code

The above information is correct to the best of my knowledge. The undersigned hereby authorizes Doctor to order radiographs (x-rays), study models, photographs, or other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I the undersigned understand that Doctor may use these x-rays, study models, photographs, or other diagnostic aids in consultation with other health care providers, teaching institution, educational purposes, and professional publications.

____ ____________

Signature of patient or responsible party   Date

Account Responsibility/Insurance Authorization

All professional services rendered are the patient's responsibility. Our office will gladly assist you by submitting information to your insurance for billing. It is customary to pay for services when rendered. I hereby authorize Doctor Matz to furnish information to insurance carriers concerning my treatment and I hereby assign to the Doctor all payments for dental services rendered to my dependents or myself. **ANY CO-PAYMENT OF INSURANCE BENEFIS IS DUE AT TIME OF SERVICE.** This amount is only an estimate and you are responsible for any differences. However if your insurance fails to pay within 60 days from the date of service, it is your responsible for the full balance at that time. We are unable to negotiate with your insurance company on your behalf. We will not bill your secondary insurance company. We can provide a claim form necessary for you to bill them after your primary insurance has paid.

CASH/CHECKS/VISA/MASTERCARD/AMEX/DISCOVER ARE ACCEPTED THERE IS A $25.00 RETURNED CHECK FEE.
I understand that I am responsible for my account, and that my insurance is essentially a contract between my insurance carrier and myself. Any account over 60 days shall be charged a finance fee of 1.5% per month, 18% per annum and/or a minimum charge of $5.00 billing fee. **IF YOU MISS AN APPOINTMENT WITHOUT GIVING 48 HOURS NOTICE WE RESERVE THE RIGHT TO DISMISS YOU AS A PATIENT.**

I, ________________________________, have read the above & understand my financial obligations & the office financial rules.

Signature: ____ Date: ____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, __________________________, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Signature: ____________________________________ Date: __________________

RISKS: Include (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications may include; swelling; sensitivity; bleeding' pain' infections; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but infrequent occasions may be permanent; reaction to injection;' changes in occlusion (biting) jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty; loosening of teeth' referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations and treatment failures. Also, the risk include possible instrument breakage, fracture or chipping of porcelain from veneers or crowns; damage to bridges, existing fillings; loss of tooth structure and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which require dental surgery.

MEDICATIONS: Some prescribed medications and drugs may cause drowsiness, lack of awareness, and lack of coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous devise until recovered from their effects.

OTHER TREATMENT CHOICES: We strive to provide all treatment options to you with any alternatives and to answer all questions concerning treatment and there risks. If you are not sure of treatment or options please ask.

CONSENT: I, the undersigned, being the patient, parent or guardian, consent to performing of procedures decided upon to necessary or advisable in the opinion of the Doctor.

Signature: ____________________________________ Date: __________________

Getting to know you

Whom may we thank for referring you?
____

Please list other family members who are patients:
____

Former Dentist_________________ Phone #________________________ Last FMX_________
Physician's Name______________________________Phone #___________________________
Address___________________________City__________________State________Zip_________

Person to contact in case of Emergency____
Phone#___________________________________Relationship___________________________
Address____________________________City_________________State________Zip_________

Closest relative not living with you_______________________Phone#_____________________
Address____________________________City_________________State________Zip________

Are you having any discomfort or pain at this time? Yes No
Are you anxious about dental treatment? Yes No
Have you ever had a bad dental experience? Yes No
Have you been a patient in the Hospital during the past two years? Yes No
Have you been under the care of a medical Doctor during the past two years? Yes No
Have you taken any medicine or drugs during the past two years? Yes No
Please List: ___________________ ___________________ ___________________
___________________ ___________________ ___________________

Is your water Fluoridated? Yes No
Are you now taking any medications or drugs? Yes No
Please List: ___________________ ___________________ ___________________
___________________ ___________________ ___________________

Do you require special attention to assist in making it a more comfortable dental visit?
____

Are you happy with your smile? Yes No
Are you comfortable smiling while around other people? Yes No
Is there anything you would care to discuss regarding changing your smile? Yes No
Tell us three hobbies or activates you are interested in:
____
____

How may we help you?
____

____
____

Are you allergic or reacted adversely to any of the following medications?

Aspirin	Nitrous Oxide (Laughing Gas)	Valium	Sleeping Pills	Dravon
Erythromycin	Penicillin	Precedent	Codeine	Tetracycline
Local Anesthetic (Novocain or Xylocaine)	Other Antibiotics	Sulfa Drugs	Latex	Other

Are you aware of being allergic to any other medications or substances? Yes No
Please List:
____
____
____

Have you ever take any of the following Medications?

Orally Administered Bisphosphonates	Actonel	Risedronate	Boniva	Ibandronate
Fosamax	Alendronate	Fosamax + D	Skelid	Tiludronate
Didronel	Etidronate	Intrevenously Administered Bishosphonates	Aredia	Pamidironate
Zometa	Zolendronic acid	Bonefos	Clodronate	

Circle any of the following, which you have had or have at present

Heart Failure	Heart Pacemaker	Prolonged cough	Glaucoma	Yellow Jaundice
Heart attack	Reaction to metals	Blood Transfusion	Rheumatism Fever	Allergies or Hives
Heart Surgery	X-ray or Cobalt treatment	Hay Fever	Anemia	Scarlet Fever
Congenital Heart Lesions	Tuberculosis	Sinus Trouble	A.I.D.S.	Cold Sores
Heart Murmur	Venereal Disease	Fever Blisters	Mitral Valve Prolapse	Rheumatism
Heart Disease	Sickle Cell Disease	Liver Disease	Stroke	Kidney Trouble
High Blood pressure	Emphysema	Angina Pectoris	Epilepsy or Seizures	Hepatitis
Ulcers	Chemotherapy (Cancer, Leukemia)	Artificial Joints and Bones (hip, knee ect.)	Pain in the Jaw Joints	Bruise Easily
Tonsillitis	Herpes	Shingles	Pacemaker	Cortisone Medicine
Diabetes	Hemophilia	Arthritis	Fainting or Dizzy spells	Nervousness
Drug Addiction	Asthma	Thyroid Disease	Other	

When you walk up the stairs or take a walk do you ever stop because of pain in your chest, shortness of breath, or because you are tired? Yes No
Do your ankles swell during the day? Yes No
Do you use two or more pillows at night? Yes No
Have you lost or gain more then ten pounds in the past year? Yes No
Do you ever wake up short of breath? Yes No
Are you on a special diet? Yes No
Has your Medical Doctor ever diagnosed you as having cancer or a tumor Yes No
Do you now or have you ever used Tobacco products Yes No
If yes which type_________ frequency__________ duration____________
Do you have any diseases or conditions not listed above Yes No

Are you pregnant? Yes No
If yes, how many weeks __________________

TMJ/ Sleep Apnea Medical Insurance Information

Medical Insurance _____________________ Employee I.D./S.S.# ___________________________ Group# ___________________

Annual Benefit ____ Phone # ________________________________

Address ____________________ City ______________________ State ________________ Zip ______