PATIENT REGISTRATION FORM

Vienna Dental Arts takes your oral health very seriously.
To help us meet all your healthcare needs, please fill out this form completely in ink.

PATIENT INFORMATION

Name (Last, First, M.I.): ________________________________SSN: ______________DOB: ______________

Gender: ☐ Male ☐ Female Marital Status (circle one): minor / single / married / other ______________

Address (city, state, zip): ____

Home Phone:______________Cell Phone:______________Work Phone:______________Ext: ________

Email Address:________________________________

Employer: ________________________________Occupation: ______________

Spouse Name:________________________________Spouse's Occupation: ______________

To whom may we thank for referring you? ________________________________

Emergency Contact:______________________Phone:______________Relation to patient:________

RESPONSIBLE PARTY (If Different from patient)

Name (Last, First, M.I.): ________________________________SSN: ______________DOB: ______________

Relation to Patient: ______________________Home Phone:______________Cell Phone:______________

Home Address (if different from patient's): ________________________________

MEDICAL HISTORY

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Please take time and fill out this section to the best of your knowledge. Thank you.

Do you have general health problem? ☐ Yes ☐ No Please specify: ______________________

Are you currently under physician's care? ☐ Yes ☐ No If "yes", please explain: ______________

Name of physician (if known): ________________________________Phone: ______________

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

Do you take or have you taken Fosamax, pills or IV ☐ Yes ☐ No

Do you use tobacco? .... ☐ Yes ☐ No If "yes", specify quantity per day ______________

Do you use controlled substances? .... ☐ Yes ☐ No

Are you currently taking any drugs or medications? ☐ Yes ☐ No Please list: ______________________

Are you allergic to: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Acrylic ☐ Metal

☐ Local Anesthetics ☐ Other, please explain ______________________ _

If female, are you: Pregnant/Trying to get pregnant? ☐ Yes ☐ No Nursing ☐ Yes ☐ No

Taking oral contraceptives? ☐ Yes ☐ No

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

Yes/No

☐ ☐ AIDS/HIV Positive
☐ ☐ Alzheimer's Disease
☐ ☐ Anemia
☐ ☐ Arthritis / Gout / Rheumatism
☐ ☐ Artificial Heart Valve
☐ ☐ Artificial Joint
☐ ☐ Asthma
☐ ☐ Blood Transfusion
☐ ☐ Cancer
☐ ☐ Chemotherapy / Radiation
☐ ☐ Chest Pains / Angina
☐ ☐ Cold Sores / Fever Blisters
☐ ☐ Congenital Heart Disorder
☐ ☐ Cortisone Medicine
☐ ☐ Diabetes
☐ ☐ Drug Addiction
☐ ☐ Emphysema
☐ ☐ Epilepsy or Seizures

Yes/No

☐ ☐ Excessive Bleeding
☐ ☐ Excessive Thirst
☐ ☐ Fainting Spells / Dizziness
☐ ☐ Frequent Cough
☐ ☐ Frequent Headaches
☐ ☐ Glaucoma
☐ ☐ Hay Fever
☐ ☐ Heart Attack/Failure
☐ ☐ Heart Murmur
☐ ☐ Heart Pace Maker
☐ ☐ Hepatitis A or B or C
☐ ☐ High Cholesterol
☐ ☐ High Blood Pressure
☐ ☐ Hives or Rash
☐ ☐ Irregular Heartbeat
☐ ☐ Kidney Problems
☐ ☐ Leukemia
☐ ☐ Liver Disease
☐ ☐ Low Blood Pressure

Yes/No

☐ ☐ Lung Disease
☐ ☐ Mitral Valve Prolapse
☐ ☐ Pain in Jaw Joints
☐ ☐ Psychiatric Care
☐ ☐ Shingles
☐ ☐ Sickle Cell Disease
☐ ☐ Sinus Trouble
☐ ☐ Spina Bifida
☐ ☐ Stomach / Intestinal Disease
☐ ☐ Stroke
☐ ☐ Swelling of Limbs
☐ ☐ Thyroid Disease
☐ ☐ Tonsillitis
☐ ☐ Tuberculosis
☐ ☐ Tumors or Growths
☐ ☐ Ulcers
☐ ☐ Venereal Disease
☐ ☐ Yellow Jaundice

DENTAL HISTORY

Name of Previous Dentist ______________________________ Location & Phone ____________________________________

What prompted you to seek dental care at this time?____

Why did you leave your previous dentist? ____

Yes / No

- Do your gums bleed while brushing or flossing? ☐ ☐
- Are your teeth sensitive to hot or cold? .... ☐ ☐
- Are your teeth sensitive to sweet or sour? .... ☐ ☐
- Are you teeth sensitive to biting pressure? .... ☐ ☐
- Do you feel pain to any of your teeth? .... ☐ ☐
- Does food constantly get stuck between certain teeth in your mouth? .... ☐ ☐
- Have you had any head, neck or jaw injuries? ☐ ☐
- Have you ever experienced any of the following problems in your jaw?
  - Clicking .... ☐ ☐
  - Pain (joint, ear, side of face)................. ☐ ☐
  - Difficulty in opening or closing .... ☐ ☐
  - Difficulty in chewing .... ☐ ☐

Yes / No

- Do you have frequent headaches? .... ☐ ☐
- Do you clench or grind your teeth? .... ☐ ☐
- Do you bite you lips or cheeks frequently? ☐ ☐
- Have you ever had any difficult extractions? ☐ ☐
- Have you ever had any prolonged bleeding following extractions? .... ☐ ☐
- Have you had any orthodontic treatment? ☐ ☐
- Do you wear dentures or partials? .... ☐ ☐
- Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ ☐
- Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc ☐ ☐
- The date of the last dental visit.............................
- How often do you brush..
- How often do you floss...

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that it is my responsibility to inform Vienna Dental Arts of any changes in medical status.

X ____ ______________________

Signature of patient (or parent/guardian if minor) Date

X____

Print name (or parent/guardian if minor)

PHOTO AND DIGTAL IMAGES CONSENT

Dear Patient:

Occasionally, we are taking pictures of your teeth, smile or of entire face. We are using them (or just keeping them on file) for Insurance and for Liability reasons. Some of the dental cases are unique and some of them are very helpful for other patients to make a decision regarding dental treatment. We do not sign your name under the images and we use them for internal office purposes only.

By signing this form, I agree to give Vienna Dental Arts, its associates and dental assistants permission to take and to use free of charge, photos and digital images of me and of my dental work for internal office use, website and for educational purposes. I understand that I may revoke permission to use my photographs / images at any time by contacting Vienna Dental Arts in writing.

Name (Last, First, M.I.): ____

(Patient/Subscriber or Guardian if a minor)

______________________________________ ______________________

Signature Date