

**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL PATIENT REGISTRATION INFORMATION FORMS USING YOUR KEYBOARD AND MOUSE. PLEASE PRINT, SIGN AND THEN MAIL, FAX OR BRING THE FORMS WITH YOU TO YOUR NEXT APPOINTMENT. OUR MAILING ADDRESS IS MICHAEL MOATS, DDS, 1401 WEST DUNDEE ROAD, PLAZA VERDE PROFESSIONAL BUILDING, SUITE 212, BUFFALO GROVE, IL 60089. OUR FAX NUMBER IS 847.392.3850**

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE				<b>1</b>
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.			FAX	
CELL			EMAIL	
BIRTHDATE	AGE	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	
MARRIED <input type="checkbox"/>	SINGLE <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	
SOCIAL SECURITY NO.				
DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		<b>2</b>
<b>PRIMARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
<b>SECONDARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

<b>ACCOUNT INFORMATION</b>		<b>4</b>
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
<b>YOU</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
<b>YOUR SPOUSE</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

<b>GETTING TO KNOW YOU</b>		<b>3</b>
<b>IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?</b>		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
<b>YOUR FORMER ADDRESS</b>		
CITY	STATE	ZIP
<b>PERSON TO CONTACT FOR EMERGENCY</b>		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

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 give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. 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 (I 8% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Patient Name

# DENTAL HISTORY

Patient Account No.

Medical Alert

*Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

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? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now?  YES  NO

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or cold?  YES  NO

Sweets?  YES  NO

Biting or Chewing?  YES  NO

Have you noticed any mouth odors or bad tastes?  YES  NO

Do you frequently get cold sores, blisters or any other oral lesions?  YES  NO

**Do your gums bleed or hurt?**  YES  NO

Have your parents experienced gum disease or tooth loss?  YES  NO

Have you noticed any loose teeth or change in your bite?  YES  NO

Does food tend to become caught in between your teeth?  YES  NO

If yes, where? \_\_\_\_\_

**Do you:**

Clench or grind your 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 & wake 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 the 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 in chewing on either side of the mouth?  YES  NO

Headaches, neckaches or shoulder aches?  YES  NO

Sore muscles (neck, shoulders)?  YES  NO

**Are you satisfied with your teeth's appearance?**  YES  NO

Would you like to keep all of your teeth all of your life?  YES  NO

Do you feel nervous about having dental treatment?  YES  NO

If so, what is your biggest concern? \_\_\_\_\_

Have you ever had an upsetting dental experience?  YES  NO

If yes, please describe \_\_\_\_\_

**Is there anything else about having dental treatment that you would like us to know?**

If yes, please describe \_\_\_\_\_

Patient Name

# MEDICAL HISTORY

Patient Account No.

Medical Alert

1. Have you been under the care of a medical doctor during the past two years?  YES  NO

If yes, for what? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. Have you taken any medication or drugs during the past two years?  YES  NO

3. Are you taking any medication, drugs or pills now?  YES  NO

If yes, please list name and dosage \_\_\_\_\_

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance?  YES  NO

If yes, please list: \_\_\_\_\_

5. Have you been a patient in the hospital during the past five years?  YES  NO

6. Indicate which of the following you have had, or have at present. Check if using your keyboard or a pen, "yes" or "no" to each item.

- |   |   |   |
|---|---|---|
| Heart (Surgery, Disease, Attack) ... <input type="checkbox"/> YES <input type="checkbox"/> NO | Ulcers ..... <input type="checkbox"/> YES <input type="checkbox"/> NO             | Hepatitis A (infectious) B (serum) ..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chest Pain ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                     | Diabetes ..... <input type="checkbox"/> YES <input type="checkbox"/> NO           | Venereal Disease ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                   |
| Congenital Heart Disease ..... <input type="checkbox"/> YES <input type="checkbox"/> NO       | Thyroid Problems ..... <input type="checkbox"/> YES <input type="checkbox"/> NO   | A.I.D.S. .... <input type="checkbox"/> YES <input type="checkbox"/> NO                            |
| Heart Murmur ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                   | Glaucoma ..... <input type="checkbox"/> YES <input type="checkbox"/> NO           | H.I.V. Positive ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                    |
| High Blood Pressure ..... <input type="checkbox"/> YES <input type="checkbox"/> NO            | Contact lenses ..... <input type="checkbox"/> YES <input type="checkbox"/> NO     | Cold Sores/Fever Blisters ..... <input type="checkbox"/> YES <input type="checkbox"/> NO          |
| Mitral Valve Prolapse ..... <input type="checkbox"/> YES <input type="checkbox"/> NO          | Emphysema ..... <input type="checkbox"/> YES <input type="checkbox"/> NO          | Blood Transfusion ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                  |
| Artificial Heart Valve ..... <input type="checkbox"/> YES <input type="checkbox"/> NO         | Chronic Cough ..... <input type="checkbox"/> YES <input type="checkbox"/> NO      | Hemophilia ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                         |
| Heart Pacemaker ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                | Tuberculosis ..... <input type="checkbox"/> YES <input type="checkbox"/> NO       | Sickle Cell Disease ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                |
| Rheumatic Fever ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                | Asthma ..... <input type="checkbox"/> YES <input type="checkbox"/> NO             | Bruise Easily ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                      |
| Arthritis/Rheumatism ..... <input type="checkbox"/> YES <input type="checkbox"/> NO           | Hay Fever ..... <input type="checkbox"/> YES <input type="checkbox"/> NO          | Liver Disease ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                      |
| Cortisone Medicine ..... <input type="checkbox"/> YES <input type="checkbox"/> NO             | Latex Sensitivity ..... <input type="checkbox"/> YES <input type="checkbox"/> NO  | Yellow Jaundice ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                    |
| Swollen Ankles ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                 | Allergies or Hives ..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Neurological Disorders ..... <input type="checkbox"/> YES <input type="checkbox"/> NO             |
| Stroke ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                         | Sinus Trouble ..... <input type="checkbox"/> YES <input type="checkbox"/> NO      | Epilepsy or Seizures ..... <input type="checkbox"/> YES <input type="checkbox"/> NO               |
| Diet (Special/ Restricted) ..... <input type="checkbox"/> YES <input type="checkbox"/> NO     | Radiation Therapy ..... <input type="checkbox"/> YES <input type="checkbox"/> NO  | Fainting or Dizzy Spells ..... <input type="checkbox"/> YES <input type="checkbox"/> NO           |
| Artificial Joints (hip, knee, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO  | Chemotherapy. .... <input type="checkbox"/> YES <input type="checkbox"/> NO       | Nervous/Anxious ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                    |
| Kidney Trouble ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                 | Tumors ..... <input type="checkbox"/> YES <input type="checkbox"/> NO             | Psychiatric/Psychological Care ..... <input type="checkbox"/> YES <input type="checkbox"/> NO     |

7. Do you use more than two pillows to sleep?  YES  NO

8. Have you lost or gained more than 10 pounds in the past year?  YES  NO

9. Do you have or have you had any disease, condition, or problem not listed?  YES  NO

If yes, please list: \_\_\_\_\_

10. Women. Are you: **Pregnant?**  YES \_\_\_ Months  NO **Nursing?**  YES  NO **Taking birth control pills?**  YES  NO

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.*

Patient /Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

History Review

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_