PATIENT REGISTRATION

***Welcome!** Please complete the following confidential information*

PATIENT INFORMATION

NAME ____
(First) (Middle) (Last)

SOCIAL SECURITY # _______________________________ DATE OF BIRTH ________________________

STREET ADDRESS ____

CITY ________________________________ STATE ____________ ZIP _______________ HOME PHONE __________________________

EMPLOYER ____ WORK PHONE __________________________________EXT:_______

CELL PHONE ____ EMAIL ____

RELATIONSHIP TO INSURANCE SUBSCRIBER (The person in your family who your insurance is through): ☐ Self ☐ Spouse ☐ Child ☐ Other

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: ____ GROUP/POLICY # ____________________

NAME OF SUBSCRIBER ____ SOCIAL SECURITY # _______________
(First) (Middle) (Last)

STREET ADDRESS ____

CITY ________________________________ STATE ____________ ZIP _______________ HOME PHONE __________________________

DATE OF BIRTH _________________ MARITAL STATUS: ☐ Married ☐ Single ☐ Other WORK PHONE ________________________EXT_____

EMPLOYER ____ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

SECONDARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: ____ GROUP/POLICY # ____________________

NAME OF SUBSCRIBER ____ SOCIAL SECURITY # _______________
(First) (Middle) (Last)

EMERGENCY CONTACT INFORMATION:

NAME OF PERSON TO CONTACT: ____

RELATIONSHIP: ☐ Spouse ☐ Partner ☐ Child ☐ Other

HOME PHONE#______________________ CELL PHONE # _______________ WORK PHONE# ________________EXT_____

WHOM MAY WE THANK FOR REFERRING YOU?

NAME OF PERSON:____

CONSENT:

1. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**: By signing below I acknowledge that I was offered a copy of this office's Notice of Privacy Practices to review according to federal and state requirements and I consent to the use of my records and information to carry out treatment, payment activities, and health care operations as set forth in this office's Privacy Notice.

2. **AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS**: Many of our patients allow family members such as their spouses, parents or others to call and request the results of xrays, treatment/ account information. Under the requirements for H.I.P.P.A we are not allowed to give this information to anyone without the patient's consent. If you wish to have your information released to family members you must authorize and sign this form. Signing this form will only give consent to release xray, treatment/account information to family members indicated below. This consent form will not allow Bernadette Tyler, D.D.S, to release any other information to these family members. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Bernadette Tyler, D.D.S., to release my xray, treatment/account information to the following individuals:

1.______________________________ Relation to patient _________________________ Phone ______________________

2.______________________________ Relation to patient _________________________ Phone ______________________

3 .**AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE:** From time to time it is necessary for representatives of Bernadette Tyler, D.D.S., to leave messages for patients. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent regarding following:

CELL#___________________________ HOME# _____________________________WORK# ________________________

4. I hereby authorize Dr. Bernadette Tyler or designated staff to take X-rays, photographs and any other diagnostic aids deemed appropriate by Dr. Bernadette Tyler to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Bernadette Tyler to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

5. **INSURANCE ASSIGNMENT AND RELEASE:** I certify that my dependent(s)and I are covered by insurance with_____________________and assign directly to Dr. __**BERNADETTE TYLER, D.D.S**.___ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance.

6. **FINANCIAL AGREEMENT:** I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. All dental work provided by Dr. Tyler is guaranteed up to one year. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

7. **I hereby authorize payment of the dental benefits, otherwise payable directly to Dr. Bernadette Tyler. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless Dr. Tyler has a contractual agreement with my plan prohibiting all or a portion of such charge. A cancellation fee will be charged for appointments cancelled or broken without 24 hours advance notice.**

8. By signing below, **I certify that I read and write English and I have read, fully understand, and agree to the above items**.

X____ ______________________________

Signature of Patient, Parent, Guardian or Personal Representative **Date**

X____ ______________________________

Please print name of Patient, Parent, Guardian or Personal Representative **Date**

MEDICAL HISTORY

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

PATIENT'S NAME: ____

Have you been under the care of a medical doctor during the past two years? …………………………………………………Yes No

If yes, for what? ____

Physician's Name _______________________________________ Telephone ___________________________________

Address ____ City ____________________ State ________ Zip _______

Are you ***ALLERGIC*** to, or have you reacted to adversely to any of the following?………………………….…………………………..

Latex Materials ………	Yes / No
Penicillin or other antibiotics………	Yes / No
Local anesthetics ("Novocain") ………	Yes / No
Codeine or other narcotics ………	Yes / No
Sulfa Drugs ………	Yes / No
Aspirin ………	Yes / No
Metals (What Type)/ Jewelry………	Yes / No
Barbiturates, sedatives, or sleeping pills………	Yes / No

Other: ____

Circle Yes or No to indicate whether or not you have had or now have the following conditions or treatments:

Heart Condition ………	Yes / No	Contact Lenses ………	Yes / No	Cortisone Medicine ………	Yes / No
Heart Attack ………	Yes / No	Glaucoma ………	Yes / No	Arthritis/Rheumatism ………	Yes / No
Heart Surgery ………	Yes / No	Bruise Easily ………	Yes / No	Fen-Phen or Redox………	Yes / No
Chest Pain (Angina) ………	Yes / No	Emphysema ………	Yes / No	Special or Restricted Diet ………	Yes / No
Congenital Heart Disease …..	Yes / No	Chronic Cough ………	Yes / No	Latex Sensitivity ………	Yes / No
Stroke ………	Yes / No	Tuberculosis (T.B.) ………	Yes / No	Cancer ………	Yes / No
High Blood Pressure………	Yes / No	Asthma ………	Yes / No	Tumors ………	Yes / No
Mitral Valve Prolapse ………	Yes / No	Hay Fever ………	Yes / No	Chemotherapy ………	Yes / No
Artificial Heart Valve………	Yes / No	Sinus Trouble ………	Yes / No	Radiation Therapy ………	Yes / No
Rheumatic Fever ………	Yes / No	Allergies or Hives ………	Yes / No	Neurological Disorders ………	Yes / No
Heart Murmur ………	Yes / No	Liver Disease ………	Yes / No	Nervous/Anxious ………	Yes / No
Heart Pacemaker ………	Yes / No	Hepatitis Type ____ ………	Yes / No	Epilepsy or Seizures ………	Yes / No
Anemia ………	Yes / No	Yellow Jaundice ………	Yes / No	Fainting or Dizzy Spells ………	Yes / No
Hemophilia ………	Yes / No	AIDS ………	Yes / No	Psychiatric/Psychological Care ..	Yes / No
Ulcers ………	Yes / No	HIV Positive ………	Yes / No	Kidney Trouble ………	Yes / No
Alcoholism ………	Yes / No	Venereal Disease ………	Yes / No	Artificial Joints or Heart Valves…	Yes / No
Drug Addiction ………	Yes / No	Cold Sores/Fever Blisters …..	Yes / No	Sickle Cell Disease ………	Yes / No
Diabetes ………	Yes / No	Blood Transfusion ………	Yes / No	Osteoporosis………	Yes / No
Family History of Diabetes …..	Yes / No	Thyroid Problems ………	Yes / No	Bone Disease or Bone Cancer…	Yes / No
		Swollen Ankles ………	Yes / No		

Do you have or have you had any disease, condition or problem not listed ……………………………………………………………… Yes No

If yes, please list: ____

Have you ever had prolonged or unusual bleeding? ……………………………………………………………………………………….. Yes No

Are you taking or have you ever taken any of the following medications: Aredia (pamidronate), Zometa (zolendronic acid), Bonefos (clodronate), Actonel (risedronate), Boniva (ibandronate), Fosamax (alendronate), Bisphosphorate (osteoporosis), Skelid (tiludronate), Didronel (etidronate)…… Yes No

Have you ever had a reaction to a local anesthetic? ………………………………………………………………………………………... Yes No

Do you use more than two pillows to sleep? ………………………………………………………………………………………………. Yes No

Do you experience frequent thirst, frequent eating or frequent urination? ………………………………………………………………. Yes No

Women: Are you pregnant?…Yes No If yes, due date: ___________ Nursing?…Yes No Taking birth control pills?…Yes No

DENTAL HISTORY

CURRENT GENERAL DENTIST ________________________________

DATE OF LAST DENTAL VISIT _______________ LAST DENTAL CLEANING _______________ LAST FULL MOUTH X-RAYS _______________

HOW OFTEN DO YOU HAVE DENTAL EXAMINATIONS? _____Seldom _____ Less than annually _____ Annually _____ Twice Annually or More

HOW OFTEN DO YOU BRUSH YOU TEETH? _______________________ HOW OFTEN DO YOU FLOSS? _________________________________

WHAT OTHER DENTAL AIDS DO YOU USE? (Mouth rinse, toothpick, etc.)

____

Have you ever had:

- Periodontal Treatment (deep cleaning or gum surgery)? ………… Yes No………. If yes, when? ____________________________
- Oral Surgery (tooth removal)? …………………….……………….. Yes No
- Orthodontic Treatment (braces)? ………………………………….. Yes No ……… If yes, when? ____________________________
- Your teeth ground or the bite adjusted? ……………….……..………. Yes No
- A bite plate or mouth guard? ……………………….……………….. Yes No

Do you smoke or chew tobacco? ……………………………………………… Yes No………. If yes, how much? ________________________

Do you clench or grind your teeth while awake or asleep? ………………….Yes No

Has any of your family members experienced periodontal disease (such as gum disease or gingivitis)? ……….………..……… Yes No………. If yes, which family members? _______________

Have you noticed any loose teeth or a change in your bite? ………………..Yes No ____

Do you mouth-breathe while awake or asleep? ……………………………Yes No

Does food tend to become caught in between your teeth? ………………….Yes No………. If yes, where? ____________________________

Do you have tired jaws, especially in the morning?………………………….. Yes No ____

Do you regularly experience clicking, popping or pain in the jaw joints?…...Yes No

Do you have difficulty in opening or closing your mouth? ……………….……Yes No

Do you chew on objects such as pencils or bite your nails? ……………….. Yes No………. If yes, what objects? _______________________

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 yes, what is your main concern? ___________ ____

Have you ever had an upsetting dental experience? ……………………….. Yes No………. If yes, please describe: ____________________ ____

Have you ever been told you need to take premedication prior to dental treatment? ____

Please explain anything else about having dental treatment that you would like us to know? _______________________________________
____
____

I understand that my medical and dental histories are necessary to provide me with periodontal care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, Dr. Bernadette Tyler has my permission to ask the respective health care provider or agency, who may release such information to Dr. Tyler. I will notify Dr. Tyler of any change in my health and/or medication(s).

Patient/Guardian's Signature ____ **Date** ____________________

MEDICATIONS

***Instructions for Patients: Please list all of the prescription and over-the-counter medications you are currently taking. If you are NOT on any medications please indicate NONE in the appropriate box.**
***List if any Surgeries within the last 6 months.**

MEDICATIONS	SURGERIES