

PATIENT REGISTRATION

First Name: _____ Last Name: _____ MI: _____

Patient Is: Policy Holder Responsible Party Preferred Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birth Date: _____ Soc. Sec. _____ Drivers Lic. _____

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

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

Physician's Name: _____ Address: _____ Phone: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ MI: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birth Date: _____ Soc. Sec. _____ Drivers Lic. _____

E-Mail: _____ I would like to receive correspondences via e-mail

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: Spouse Child Other

Insured Soc. Sec. _____ Insured Birth Date: _____

Employer: _____ Address: _____

Address 2: _____ City, State, Zip: _____

Insurance Company: _____ Address: _____

Group #: _____ Policy #: _____ City, State, Zip: _____

Secondary Insurance information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured So. Sec. _____ Insured Birth Date: _____ Employer: _____

Employer Address: _____ City, State Zip: _____

Insurance Company: _____ Address: _____

City, State, Zip: _____

Group #: _____ Policy #: _____

Health History Form

ADA American Dental Association®

America's leading advocate for oral health

Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name Last First Middle			Home Phone: include area code ()	Business/Cell Phone: include area code ()		
Address: Mailing address			City	State	Zip	
Occupation			Height	Weight	Date of Birth	Sex M F
SS# or Patient ID	Emergency Contact		Relationship	Home Phone: include area code ()	Cell Phone: include area code ()	
If you are completing this form for another person, what is your relationship to that person?						
Your Name			Relationship			
Do you have any of the following diseases or problems:			(Check DK if you Don't Know the answer to the the question)			Yes No DK
Active Tuberculosis						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.						

Dental Information For the following questions, please mark (X) your responses to the following questions

Do your gums bleed when you brush or floss?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:	
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY		What was done at that time?	
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:	
What is the reason for your dental visit today?			
How do you feel about your smile?			

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Are you now under the care of a physician?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name:	Phone: include area code ()	If yes, what was the illness or problem?	
Address/City/State/Zip		Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:	
Has there been any change in your general health within the past year?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	
If yes, what condition is being treated?		_____	
Date of last physical exam:		_____	

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<small>(Check DK if you Don't Know the answer to the question)</small>		Yes No DK		Yes No DK	
Do you wear contact lenses?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____ If yes, have you had any complications? _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax [®] , Actonel [®] , Atevia, Boniva [®] , Reclast, Proka) for osteoporosis or Paget's disease?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia [®] , Zometa [®] , XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date Treatment began: _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Allergies. Are you allergic to or have you had a reaction to To all yes responses, specify type of reaction.		Yes No DK		Yes No DK	
Local anesthetics _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Metals _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Aspirin _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Latex (rubber) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Penicillin or other antibiotics _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Iodine _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Barbiturates, sedatives, or sleeping pills _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay fever/seasonal _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Sulfa drugs _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Animals _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Codeine or other narcotics _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Food _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
			Other _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.					
		Yes No DK		Yes No DK	
Artificial (prosthetic) heart valve		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Previous infective endocarditis		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Damaged valves in transplanted heart		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Systemic lupus erythematosus	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Congenital heart disease (CHD)			Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Unrepaired, cyanotic CHD		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Repaired (completely) in last 6 months		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Emphysema	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Repaired CHD with residual defects		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<small>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD</small>			Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
		Yes No DK	Cancer/Chemotherapy/ Radiation Treatment	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Cardiovascular disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chest pain upon exertion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Angina	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pacemaker	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diabetes Type I or II	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatic heart disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart murmur	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	G.E. Reflux/persistent heartburn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, date: _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ulcers	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
High blood pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Thyroid problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other congenital heart defects	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Name of physician or dentist making recommendation			Phone (include area code)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
			()		
Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain.				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian _____

Date _____

Signature of Dentist _____

Date _____

FOR COMPLETION BY DENTIST

Comments _____

BRISTOL Family DENTAL

Authorization and Consent for Services

I, _____, hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect information has the potential of being hazardous to your health.

As a condition of treatment of this office, financial arrangements **must be made in advance**. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any other dental services performed without previous financial arrangements, must be paid in full at the time of service.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on my dependent (if any).

A finance charge of 1% per month (18% per year) on any unpaid balance will be charged on all accounts exceeding sixty days. If legal or collection services are required to obtain payment, I understand that I will be responsible for all collection and legal costs associated with this debt.

*Cancellation Policy:

An appointment at Bristol Family Dental, is a reservation. If you are unable to keep your scheduled appointment, we require at least a 24 hour notice, or a fee will be assessed as follows: \$50 for all appointments 1 hour or less, and \$100 for all appointments over 1 hour. Also, if you fail to give proper notice, in order to book another appointment over 1 hour, we will kindly ask you to pay 50% of your portion to hold that time for you. We appreciate your understanding in this matter. **PLEASE INITIAL** _____

*Payment options:

*Visa, MC, Amex, Disc, Cash, Check, Care Credit

* 5% courtesy is given if a multi-appointment treatment plan if paid in full at or before the first appointment. Cannot be combined with dental insurance.

*10% courtesy is given to seniors with no dental insurance or the membership plan, and only applies if paid in full.

Patient/Guardian Signature: _____ Date: ____/____/2021

BRISTOL Family DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

I acknowledge the following party and or parties to be privy to my health information. Please state **name, relationship & best way to contact** the appropriate party.

1. _____
2. _____
3. _____

Please Print Your Name

Signature

Date

* You may refuse to sign this acknowledgement *

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)