Heritage
Family Dental, P.C.

Adult Patient Registration

Patient Information

Name: _____ ____ _____ I prefer to be called: _____
First MI Last

Birthdate: _____ SS# _____ □Male □Female
month/day/year

□Single □Married □Divorced □Widowed □Separated

Mailing Address:	Physical Address (if different):
City State Zip	City State Zip

Employer: _____ How Long? _____

Telephone Contact Numbers

Home:	Work:
Mobile:	Other:

May we call you at work? □Yes □No

Best time to reach you: □Mornings □Afternoons

At which number: □Home □Work □Mobile □Other

Please indicate the contact numbers that we have permission to leave a detailed message:
□NONE □Home □Work □Mobile □Other

Email:

Do you have pre-school or school-aged children living in your household that need to have dental appointments arranged at our office? □Yes □No

First Name	Last Name	Age

Dental Insurance Information □ *Insurance card(s) copied* □ *No Insurance*

Primary DENTAL Insurance	Secondary DENTAL Insurance
Insurance Company	Insurance Company

Credit Card to be kept on file

Credit Card Information (Please Check One of the Following)
_____ VISA _____MasterCard _____American Express _____Discover

Credit Card #_____ Expiration Date_____ Security Code _____

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ADULT MEDICAL HEALTH HISTORY

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____

Who may we THANK for referring you? _____

Date of last physical/medical exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? No Yes

If yes, reason: _____

Please list the names, phone numbers, and reasons for any physicians who are currently providing you care:

Physician Name	Office Number	Reason for care

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder	No	Yes	Heart Disease, Heart Attack, Heart Surgery	No	Yes
Arthritis, Rheumatism, or other inflammatory disease	No	Yes	Hepatitis (any form)	No	Yes
Asthma	No	Yes	High Blood Pressure	No	Yes
Abnormal bleeding from a cut	No	Yes	Joint Replacement, when placed?	No	Yes
Cancer or Tumor	No	Yes	Kidney Disease	No	Yes
Diabetes	No	Yes	Psychiatric Conditions	No	Yes
Emphysema, COPD, or Respiratory/Lung Illnesses	No	Yes	Radiation or Chemotherapy Treatment, when?	No	Yes
Glaucoma	No	Yes	H.I.V. Infection/AIDS	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Recurrent Illnesses		
Heart Valve (artificial) or Heart Transplant	No	Yes	Other Conditions (list below)	No	Yes

Have you been told you require antibiotics prior to any dental appointment? For what condition?	No	Yes

Women Only

□ **NA**	Is there any chance you could be pregnant today?	No	Yes
	If no, are you planning a pregnancy in the near future?	No	Yes
	Are you a nursing mother?	No	Yes
	Are you taking birth control pills (to include Murena, contraceptive implants, or injections (Depo-prova)?	No	Yes

List any other conditions:

Medications

□ ***I do not take any medications/supplements*** □ ***I brought in a copy/list of my medications***

Are you taking any of the following medications?

Do you take blood thinners such as Warfarin, Coumadin, Xarelto, or Plavix?	No	Yes
Have you been treated for osteoporosis with Fosamax, Aredia, Zometa, Actonel, or Boniva? If so, when did the treatment begin? When did the treatment end?	No	Yes
Do you take prescription narcotics such as Vicodin, Lortab (hydrocodone), Percocet(oxycodone), oxycontin, Tylenol with Codeine, morphine, methadone, or suboxone	No	Yes
Do you take Non-Steroidal Anti-inflammatory drugs (NSAIDs) such as Aspirin, Motrin (ibuprofen), Aleve (naproxen), or Celebrex (celecoxib)	No	Yes

Please list all prescription and over the counter medications you are currently taking, including dosages:

Medication	Dose	Medication	Dose

Please list any dietary or herbal supplements you are taking, and for what purpose:

Supplement	Purpose	Supplement	Purpose

Are you allergic or have you had a reaction to:			Type of reaction
Dental anesthetics	No	Yes	
Penicillin	No	Yes	
Other antibiotics	No	Yes	
Aspirin, Ibuprofen, or Tylenol	No	Yes	
Codeine, Valium, or other sedatives	No	Yes	
Latex	No	Yes	
Metals	No	Yes	
Other (please specifiy)	No	Yes	

Tobacco, Alcohol, and other Drug use

Do you use tobacco? If yes, circle type: *smoke vape/e-cig dip chew* How much per day? *Less than half a pack half a pack to 1 pack More than 1 pack* For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any other mood altering drugs (illicit/illegal/street drugs) not already listed?	No	Yes

ADULT DENTAL HEALTH ASSESSMENT

When did you last see a dentist?

Are you currently experiencing any dental pain or swelling that has caused you to miss work/school, prevented you from sleeping through the night, or prompted you to seek care at an Urgent Care or Emergency Room?	No	Yes

Do you have any dental issues or concerns that you would like to discuss with the dentist today?	No	Yes

Is there anything we can do to make your appointments more comfortable?

What is your ultimate goal regarding your dental health?

Are you apprehensive about dental treatment?	No	Yes
Would you prefer nitrous/laughing gas for future dental treatments?	No	Yes
Are your teeth sensitive?	No	Yes
Are you interested in teeth whitening treatments?	No	Yes
Are you aware of if you grind or clench your teeth?	No	Yes
Do you use a mouthguard when you sleep?	No	Yes
Have you ever been told you have gum disease (periodontitis), had gum treatments (deep cleanings or scaling/root planing), or seen a specialist for gum disease (periodontist)?	No	Yes
Do your gums bleed when you brush or floss?	No	Yes
Have you had your wisdom teeth removed?	No	Yes
Have you had a crown or bridge made? When was the most recent crown/bridge made:	No	Yes
Do you use any removable appliance (partial, denture, retainer)? Approximate age of appliance:	No	Yes
Do you have missing teeth that you are wanting to have replaced?	No	Yes
Do you notice having "dry mouth" or inadequate saliva on a regular basis?	No	Yes

Please let us know any other information that may help us to provide you with optimum dental care.

I have reviewed the Policies listed below and agree to comply with these policies as a requirement for me to continue as a patient with Heritage Family Dental.

□ *I decline receiving a copy of these policies for my personal records.*
□ *I would like a copy of these policies for my personal records.*

***Initial* the following Policies reviewed**

_____ About your dental insurance
_____ Appointment Policy
_____ Comprehensive Care Philosophy
_____ Financial Policy
_____ HIPAA

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 Dentist of any changes to my health and medication.

I also consent to have the necessary radiographic images and diagnostic tests completed as prescribed by the Dentist in order to adequately assess my current oral health and to determine a plan of treatment with consideration based upon the data collected through a clinical examination, Dentist's interpretation of the radiographic images/diagnostic tests, and my personal oral health goals.

_____ _____ _____
Patient/Guardian (Print Name) *Patient/Guardian Signature* *Date*

_____ _____ _____
Dentist (Print Name) *Dentist Signature* *Date*

Permission to Share Medical/Dental Information

At Heritage Family Dental, we understand that the privacy of your personal information is important to you. Therefore, we will not discuss appointment dates/times, treatments or procedures, financial information, or any other personal information with anyone but you and those parties associated with your direct treatment (other medical/dental professionals, their treatment teams, and your insurance company), unless you give us written authorization to do so.

Please initial next to your choice. More than one may be selected.

____ I authorize my medical and dental information to be obtained and/or exchanged with the following individual(s) without restriction.

Name	Relationship

____ In the event of an emergency, I authorize the following individual(s) to be contacted. My medical and dental information is to be obtained and/or exchanged only for the purpose of notifying the authorized individual.

Name	Work#	Home or Cell#	Relationship

____ In the event Heritage Family Dental cannot reach me at my listed phone numbers, they may also call the following individual(s) to relay a message to me.

Name	Contact#	Relationship	May we leave a detailed message?	Message Restrictions
			Yes No	□Please call the office □Appointment reminder □Other:
			Yes No	□Please call the office □Appointment reminder □Other:
			Yes No	□Please call the office □Appointment reminder □Other:

____ I DO NOT authorize any information to be obtained and/or exchanged with any individual.

These authorizations may be modified or changed at anytime with written consent from the patient only. The authorizations on this form expire automatically after one year at which point, a new form must be completed. Upon expiration, NO medical or dental information will be obtained and/or exchanged with any individual.

_____ _____

Patient (Parent or Legal Guardian) Signature Date