Patient Information

Patient Name: _____/_____ Date:_____
Last First MI (preferred name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other Email address _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Whom may we thank for referring you to our practice? _____

In case of emergency, please contact (name)_____at (____)_____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergy to foods
_____
☐ Allergy to medication
  ☐ Codeine
  ☐ Penicillin
  ☐ Sulfa
  ☐ Other (list)
_____
☐ Allergy – other
_____
_____

☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Cancer
☐ Cardiac Condition
  ☐ Heart Disease
  ☐ Heart Surgery
  ☐ Heart Murmur
  ☐ Mitral Valve Prolapse
_____
☐ Cosmetic Implants
☐ Diabetes
☐ Dizziness / Fainting

☐ Epilepsy
☐ Excessive Bleeding
☐ Glaucoma
☐ Head Injuries
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
  Due date:_____

☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Ulcers
OTHER MEDICAL – list:

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- List any medications, supplements, homeopathics and/or herbs you are taking: _____

_____

Dr. Regiani is well educated in alternative therapies. We can offer homeopathic as well as conventional drug medications. If you need medications, which would you prefer: *(number 1st, 2nd, 3rd choice, if applicable)*

For pain: Traditional:_____ Homeopathic_____ Other_____
Antibiotic/Infection: Traditional:_____ Homeopathic_____ Other_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

I hereby authorize Dr Regiani and his staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my (or my child's) dental needs.

Upon such diagnosis, I authorize Dr Regiani and his staff to perform all recommended treatment and to employ such assistance as required to provide proper care, including consultation with my health care provider(s).

I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents carries certain risks, and I understand I may ask for a full recital of possible complications.

As a condition of treatment, payment is expected at time of service unless written financial arrangements are made and signed with this office. I understand that any fee estimate is valid for treatment that begins within 90 days from the date of the examination, and is subject to change due to unforeseen circumstances. A finance charge of 1-1/2% per month (18% APR) is added to unpaid balances at 60 days after treatment. If no payments are received within a 90 day period, collection action will commence, and I agree to pay all attorney and legal fees associated with collecting my unpaid delinquent balance.

I have read and understand the above conditions of treatment and payment.

Signature of Responsible Party_____ Date:_____

Printed name, if not signed by patient_____ Relationship:_____

Dental History for _____

Patient's Name

Welcome! So that we may provide you with the best possible care, please complete this form as accurately as possible. If you have dental insurance information, please fill the requested information on the reverse. All information is kept confidential.

This information is for: ☐ myself ☐ my child ☐ other_____

What is the reason for your visit today?_____

When was your last dental visit?_____ What was done?_____

Previous Dentist's name & location_____

How often do you have dental examinations?_____

How often do you brush?_____ How often do you floss?_____

Do you feel nervous about having dental treatment?_____ Why?_____

Have you ever had an upsetting dental experience?_____ What?_____

Do you have any of the following? Please check those that apply:

☐ Sensitive teeth
- ☐ Hot or cold?
- ☐ Sweets?
- ☐ Biting / Chewing?
- ☐ When you breathe in?
- ☐ Other problem – describe:

_____

☐ Mouth Odor or bad taste
☐ Frequent cold sores, blisters or oral lesions?
☐ Do your gums bleed or hurt?
☐ Told you have gum disease?
When?_____
☐ Do you have loose teeth?
☐ Does food "catch" between your teeth?
Where?_____
☐ Do you notice a difference in the way your teeth "bite"? _____
☐ Would you like to keep all your teeth all your life?_____
Do you like the way your teeth look?
☐ Yes ☐ No

Have you ever had:
☐ Periodontal therapy, describe:

_____

Do You:
☐ Clench or grind your teeth
- ☐ When asleep?
- ☐ When awake?
- ☐ When stressed?

☐ Bite foreign objects? (pencils, fingernails, etc.)
☐ Bite lip or cheek regularly?

☐ Mouth breathe
- ☐ When asleep?
- ☐ When awake?
- ☐ Only when you have a cold?

☐ Smoke or chew tobacco?
How frequently_____
☐ Do you snore?
How frequently_____
☐ Have tired jaws, especially when you wake in the morning?
Do you wake and feel refreshed?
☐ Yes ☐ No

Have you ever had:
☐ Oral surgery, describe:

_____

Have you ever had:
☐ Orthodontic treatment
☐ Teeth removed for spacing
☐ Wear a retainer
☐ TMJ / TMD treatment
- ☐ Bite Splint
- ☐ Mouth guard
- ☐ Medication for TMJ
- ☐ Equilibration
- ☐ Physical Therapy
- ☐ Counseling
- ☐ Surgery

☐ Serious injury to mouth or head?
☐ Clicking or popping in jaw
☐ Sore jaw from talking
☐ Head, neck or shoulder aches
☐ Pain in jaw joint, ear or side of face
☐ Difficulty in chewing on both sides of your mouth.
☐ Tenderness or difficulty in opening wide.
☐ Has you jaw ever locked
- ☐ Open?
- ☐ Closed?

- Do you often feel you are excessively tired during the day? ☐ Yes ☐ No
- Has anyone noted difficulty with your breathing patterns at night? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- If there is anything you would like to change about your teeth or your smile, what would it be?

  _____
- Are you now under the care of a Dental Specialist? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Specialist:_____ Phone:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

_____ Date:_____

Signature of patient, parent or guardian