Patient Registration Form

Patient Name: ______________________________ Birthdate: ______________
SS #: ______________________________ Sex: Male Female
Marital Status: Single Married Divorced Widowed Partnered
Home Address: ______________ City: ______________ State: __________ Zip: ________
House Phone: ______________________________ Cell Phone: ______________
Employer: ______________________________ Work Phone: ______________
What is the best way to contact you: Home Cell Work Email
Email Address: ______________________________

Who may we thank for referring you? ______________________________
*Please list a Emergency Contact (Name/Phone): ______________________________

Responsibility Party

Name of person responsible for the account: ______________________________ Relationship: ______________

Dental Insurance

Subscriber's Name: ______________________________ Relationship: ______________
Birthdate: ______________ ID #: ______________ Group #: ______________
Insurance Company: ______________________________ Insurance Phone Number: ______________
Employer's Name: ______________________________ Employer Phone Number: ______________

Dental History

Former Dentist: ______________________________ Phone Number: ______________
Why did you leave your previous dentist? ______________________________ May we contact: YES NO
What is the most important reason for you dental visit today? ______________________________
The most important thing about your future smile and dental health is: ______________________________

Do any of the following apply to you?

Sensitivity (Hot/Cold/Sweets)	YES	NO	Food Collection Between Teeth	YES	NO
Headaches, Earaches, Neck Pain	YES	NO	Jaw Joint pain, Grinding, Clenching	YES	NO
Teeth or Fillings breaking	YES	NO	Bad breath	YES	NO
Bleeding, Swollen or Irritated gums	YES	NO	Loose, Tipped or Shifted Teeth	YES	NO

Do you have/had any of the following? Dentures Partials Braces Periodontal (gum) Treatment

Authorization and release
I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental cure to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly so the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature: ______________________________ Date: ______________

Acknowledgement Of Receipt Of Notice Of Privacy Practices

I, ______________________________ , have received a copy of the Notice of Privacy Practices for Philip L. Younts D.D.S.
Signature: ______________________________ Date: ______________

Health History

Physician's Name: ______________________ Phone: ______________ Last Exam: ____________

Have you been hospitalized within the last 5 years? YES NO If yes, reason: ______________________

For the following please check 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 responses. Our staff may ask additional questions regarding your health.

YES	NO	Anemia	YES	NO	Hepatitis Any Form
YES	NO	Arthritis, Rheumatism or Inflammatory Disease	YES	NO	Artificial Joint Replacement, Where?
YES	NO	Asthma	YES	NO	Kidney Disease
YES	NO	Abnormal Bleeding	YES	NO	Liver Disease
YES	NO	Cancer or Tumor	YES	NO	Sore/Enlarged Lymph Nodes
YES	NO	Diabetes	YES	NO	Psychiatric Care
YES	NO	Emphysema or Respiratory/Lung Illness	YES	NO	Previous Biopsies
YES	NO	Epilepsy	YES	NO	Radiation/Chemotherapy Treatment
YES	NO	Fainting or Dizzy Spells	YES	NO	Rheumatic Fever
YES	NO	Glaucoma	YES	NO	Unconventional Weight Gain/Loss
YES	NO	Abnormal Heart/Bacterial Endocarditis	YES	NO	H.I.V Infections AIDS or ARC
YES	NO	Heart Valve (artificial) or Heart Transplant	YES	NO	Venereal Disease
YES	NO	Heart Disease, Heart Attack, Heart Surgery	YES	NO	Tuberculosis
YES	NO	Heart Murmur	YES	NO	Stroke
YES	NO	Heart Stint Placed, When?	YES	NO	Pacemaker
YES	NO	Mitral Valve Prolapse	YES	NO	Back Problems
YES	NO	Thyroid Problems	YES	NO	Swelling of Feet or Ankles

Abnormal Blood Pressure? YES NO If yes, is it high or low? ______________________

Have you ever received a diagnosis of "High blood pressure"? YES NO If yes, are you under a doctor's care? YES NO

Women: are you pregnant? YES NO If no, are you planning a pregnancy in the near future? YES NO

Are you a nursing mother? YES NO Are you taking birth control? YES NO

Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? YES NO

If yes, when did treatment start: ______________________

Please list any medications or dietary/herbal supplements you are currently taking and for what purpose:

1. ____________	6. ____________
2. ____________	7. ____________
3. ____________	8. ____________
4. ____________	9. ____________
5. ____________	10. ____________

Do you need to be pre-medicated with antibiotics before a dental visit? YES NO

Are you allergic or have reactions to:

Local Anesthetics	YES	NO	Codeine, Valium or other sedatives	YES	NO
Penicillin or other antibiotics	YES	NO	Latex	YES	NO
Aspirin, Ibuprofen, Tylenol	YES	NO	Metals	YES	NO

Others (Please Specify): ______________________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect can be dangerous to my health.

Signature: ______________________ Date: ______________