DENTAL REGISTRATION AND HISTORY

This information is necessary for our files and your health and will be considered CONFIDENTIAL

PATIENT INFORMATION

Patient Name _____ Date_____

Birthdate_____ S.S.#_____Male ☐ Female ☐

Residence Street Address _____

City _____ State_____ Zip Code _____

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Employer _____

Employer Address _____

Spouse's Name _____

Spouse's Employer _____

Whom may we thank for referring you?_____

PHONE NUMBERS

Home ( ) _____ Work ( )_____ Ext_____

Cell ( )_____Spouse's Work_____ Email_____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone ( )_____ Work Phone ( )_____

DENTAL INSURANCE

No dental insurance ☐

Insurance Company Phone Number_____ Group#_____

Subscriber's Name _____ Subscriber's SSN_____

Subscriber's Birthdate _____ Subscriber's Employer _____

Do you have additional dental insurance? Yes ☐ No ☐

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I or my dependent have insurance coverage and assign directly to Dr. Brad Justesen all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that all dental services furnished are charged directly to the patient, and that the patient is personally responsible for payment of all dental services. I understand the dental office will help to prepare the patient's insurance forms to assist in making collections from insurance companies and will credit any such collections to the patient's account. I also understand that this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

_____ _____ _____

Responsible Party's Signature Relationship Date

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

DOB _____

DENTAL HISTORY

Date of last dental visit_____ Date of last dental x-rays_____

Former Dentist _____City/State_____

Have you ever had any serious trouble associated with any previous dental procedure? Yes ☐ No ☐

If yes, please explain _____

Does dental treatment make you nervous? Yes ☐ No ☐ If yes, check: Slightly ☐ Moderately ☐ Extremely ☐

Have you ever had: orthodontic treatment? Yes ☐ No ☐ Periodontal (gum) treatment Yes ☐ No ☐

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

Do you have any problem with any of the following?

	Yes	No		Yes	No
Unfavorable reaction from dental anesthetic	☐	☐	Bad Breath	☐	☐
Swollen, tender, bleeding gums	☐	☐	Dry mouth/Mouth breather	☐	☐
Smoke or chew tobacco	☐	☐	Clicking or popping jaw	☐	☐
Food collection between the teeth	☐	☐	Grinding teeth	☐	☐
Sensitivity to hot, cold, sweets	☐	☐	Jaw pain or tiredness	☐	☐
Sensitivity to biting or pressure	☐	☐	Sores or growths in mouth	☐	☐
Loose teeth or broken fillings	☐	☐	Mouth pain with brushing	☐	☐

If there were something you would change about your smile, what would it be?_____

MEDICAL HISTORY

Physician's Name_____Phone Number _____ Date of last visit_____

Are you under the care of a physician? Yes ☐ No ☐ If yes, what for _____

Have you ever had any serious illness or operation? Yes ☐ No ☐ If so, explain_____

Are you pregnant? Yes ☐ No ☐ How many months_____ Do you take birth control pills? Yes ☐ No ☐

Do you have, or have you had any of the following?

☐ Arthritis
☐ Anemia/Blood disorder
☐ Aneurism
☐ Artificial Joint
☐ Asthma
☐ Diabetes
☐ Epilepsy
☐ Fainting Spells
☐ Fosamax/Boniva/Biphosphonates
☐ Glaucoma
☐ HIV/AIDS
☐ Heart Murmur
☐ Rheumatic Fever
☐ Hepatitis A,B,C
☐ High Blood Pressure
☐ Kidney Problems
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Psychiatric Problems
☐ Radiation Therapy
☐ Sinus Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumor History
☐ Ulcers
☐ Venereal Disease
☐ Taken Fen-Phen

ALLERGIES

Yes ☐	No ☐	Aspirin
Yes ☐	No ☐	Codeine
Yes ☐	No ☐	Dental Anesthetics
Yes ☐	No ☐	Erythromycin
Yes ☐	No ☐	Jewelry
Yes ☐	No ☐	Latex
Yes ☐	No ☐	Metals
Yes ☐	No ☐	Penicillin
Yes ☐	No ☐	Tetracycline

OTHER:_____

_____

_____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis

_____

Pharmacy Name_____Phone Number _____

CONSENT FOR TREATMENT/TERMS & CONDITIONS

I hereby grant authority to Dr. Brad Justesen to administer any treatment; or to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such treatment as may be deemed necessary or advisable. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. If for any reason my unpaid balance exceeds 90 days I understand that a service charge of 1.5% (18% per annum) will be charged to my account. I further agree and understand that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable collection/attorney fees if a suit be instituted hereunder.

I have read the above consent for treatment and terms & conditions and agree to their content.

Signed _____ Date_____