PATIENT REGISTRATION

(Adult)

Today's Date _____ Patients Date of Birth _____

Patients Full Name _____ Single _____
Married _____
Street Address _____Divorced _____
City _____ State _____ Zip Code _____Home # _____
Patients E-Mail Address _____ Patients cell # _____
Patients Social Security # _____ Patients Drivers license # _____

Name of Spouse _____ Spouse's Date of Birth_____
Spouses Social Security # _____ Spouses Drivers license # _____
Spouses E-Mail Address _____ Spouses Cell# _____

In case of an Emergency, Whom should we notify? _____Phone#_____

Patients Employer _____ Phone _____
Business Address _____
Present Position _____ How long held? _____

Spouses Employer _____ Phone _____
Business Address _____
Present Position _____ How long held? _____

Are you covered under any Dental Insurance? Yes _____ No _____

As a service to our patients, we will process dental insurance under two conditions:

1) ***You provide us with the necessary insurance information (see below)***
2) ***You pay your estimated portion of our fee at the time of service***.

PRIMARY

If yes, Name of Insurance Company _____ Phone _____
Claims Mailing Address _____
Name of primary Subscriber _____ Group Number _____

Whom may we thank for referring you to our office? _____
Comments_____
_____

Patients Signature _____ Date _____

(OVER)

HEALTH HISTORY

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to any one without your written permission.

The name of my physician is _____ Phone _____
Have you had any serious illness or operation? Yes _____ No _____
If yes, please explain. _____
Do you need to take any type of Pre-Medication before dental appointments? Yes No
If so, what is the reason _____RX :_____

Do you have or have you had any of the following diseases or problems?

Heart disease	Yes No	Tuberculosis	Yes No
Congenital heart lesions	Yes No	Epilepsy	Yes No
Rheumatic fever	Yes No	Multiple Sclerosis	Yes No
M.V.P. Yes No	Kidney trouble	Yes No	
Fainting spells	Yes No	Candida	Yes No
Hives or skin rash	Yes No	AIDS	Yes No
Inflammatory rheumatism	Yes No	Herpes	Yes No
Stroke Yes No	Hepatitis	Yes No	
HearingYes No	High/Low blood pressure	Yes No	
Diabetes	Yes No	Asthma	Yes No
Joint replacement	Yes No	Alcoholism or drug dependency	Yes No

Other _____

Are you allergic or reacted adversely to?

Local anesthetics	Yes No	Other Antibiotics	Yes No
Penicillin	Yes No	Sedatives	Yes No
Tetracycline	Yes No	Iodine	Yes No
Aspirin Yes No	Ibuprofen	Yes No	
Acetaminophen	Yes No	Codeine	Yes No

Other _____

Are you taking any of the following medicines or drugs?

Antibiotics or Sulfa drugs	Yes No	Cortisone	Yes No
Anticoagulants	Yes No	Tranquilizers	Yes No
Blood Pressure Medicine	Yes No	Aspirin	Yes No
Insulin or similar drug	Yes No	Acetaminophen	Yes No
Digitalis or Heart medicine	Yes No	Nitroglycerin	Yes No

Other _____

Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No
Have you had surgery or X-Ray treatment for a tumor, growth or other condition of your mouth or lips? Yes No
Have you had any serious trouble associated with any previous dental treatment? Yes No
If yes to any of the above questions, please explain _____
Do you have any disease, condition or problem not listed above that you think we should know about? _____
_____
Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? Yes No

Women

Are you pregnant? Yes No if so, what's your due date? _____

_____ _____
(Signature of Patient) (Date) (Signature of Dentist) (Date)

CONSENT FOR SERVICES

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

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient's account and that he or she is personally responsible for payment of all dental services not covered by the insurance company. This office will help prepare the patients insurance form or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Patients are required to pay their estimated portion of the services rendered at the time of service.

A Service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination and is subject to insurance benefits.

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 doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of anytime or condition hereunder shall not constitute a wavier of any further term of condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I understand that I will be charged a $50.00 "Broken Appointment Fee" if I fail to keep an appointment of if I don't give at least 24 hours notice when canceling an appointment except in the case of an emergency.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their consent.

Signature of patient, parent or guardian Date Relationship to patient

PATIENT QUESTIONAIRE

1) What is the reason for your initial appointment?

2) If there was a simple inexpensive way to whiten your teeth would you do it?

3) If you could wave a magic wand and change anything about your teeth, What would it be?

4) Why did you leave your previous dentist?

5) What did you like the most about any dentist you have seen?

6) Have you ever experienced any cold-sore or canker- sore symptoms?

7) Do you clench or grind your teeth?

8) Do your gums bleed when you brush or floss?

9) Are you experiencing any oral discomfort?

10) Are your teeth sensitive to hot or cold?

11) Is snoring a problem?

PARKER M. JARVIS, D.D.S.

Smile Evaluation Checklist

Name:_____ Date:_____

To aid in our diagnosis and treatment of your aesthetic concerns, please take a moment and answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?	YES	NO
Do you have spaces between your teeth that bother you?	YES	NO
Do you have chips or uneven edges on your teeth?	YES	NO
Do you feel that your teeth are too long or too short?	YES	NO
Do you have dark fillings that show when you smile?	YES	NO
Do your gums show too much when you smile?	YES	NO
Are your teeth crowded or crooked?	YES	NO
Do you have existing dental work that you do not like?	YES	NO
Are you self conscious of your teeth and/or smile?	YES	NO
Has anyone (friend/family, etc.) ever suggested that you should have something done with your teeth or smile?	YES	NO
Do you avoid smiling when you have your picture taken?	YES	NO
Would you like to improve your existing smile?	YES	NO
Do you wish you had a “new smile”?	YES	NO