AD
ALIGN DENTAL

Patient Registration & Dental History

Please take a few minutes to fill out this form as completely as possible. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name____
Last First Middle Initial

Social Security__________-__________-__________

Home phone (______)______________Work phone (_______)______________Cell phone (_______)________________

Address____
Street Apt# City State Zip code

Date of Birth__________________ Age _________ Sex _________Male Marital Status __________Single
_________ Child _________ Female __________ Married

Patient Employer/School______________________________Employer phone (_____)________________
Pharmacy name, town and phone #______________________________
Emergency Contact name and phone______________________________
Email address______________________________Whom may we thank for referring you?__________________

Primary Dental Insurance

Do you have dental insurance? Yes_________ No__________(To be completed by parent or guardian if patient is a minor)
Person responsible for payment ______________________________
Last First Middle Initial

Relation to patient______________________Date of Birth_____________ Social Security ________-________-________
Address (if different than patient's)______________________________
Street City State Zip Code

Responsible party Employer______________________________Occupation______________________
Employer Address______________________________ Employer phone #__________________
Insurance Company______________________________Group #________________ Subscriber #________________
Name of all dependents covered by this plan______________________________
Is the patient covered by any additional insurance?_________ If yes, please list secondary provider____________________

Dental History

Reason for visit____________________________Former Dentist______________________ City/State_____________
Date of last dental visit______________________ Date of last x-rays ______________________________

Check to indicate if you have any of the following:

_____ Bad breath	_____Grinding teeth	_____Pain around the ear	_____Bleeding Gums
_____ Bleeding Gums	_____Gums swollen/tender	_____Periodontal treatment	_____Broken fillings
_____ Jaw pain or tiredness	_____ Sores in mouth	_____Clicking/popping jaw	_____Lip/Cheek biting
_____ Sensitivity to cold	_____ Sensitivity to heat	_____Dry mouth	_____Loose teeth
_____ Fingernail biting	_____Mouth breathing	_____Sensitivity to sweets	_____Mouth pain
_____ Foreign objects	_____ Orthodontic treatment	_____Sensitivity when biting	_____Food collection in teeth

Please Complete Both Pages

AD

ALIGN DENTAL

Patient Registration & Dental History

Medical History

Physician's name_______________________________ Date of last visit_______________________
Have you ever taken any of the drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names for Phentermine), Podimin and Redux. ______Yes ______No
Have you ever had any serious illness or operations? ________Yes _________No If yes, please describe_____________________
____

Have you ever had a blood transfusion? ______Yes ________No If yes, please give approximate dates______________________
(Woman only) Are you pregnant, nursing or taking birth control pills?_______________________________________

Check to indicate if you have any of the following:

_____ Anemia	_____ Arthritis, Rheumatism	_____ Artificial Heart Values	_____ Artificial joints
_____ Asthma	_____ Back problems	_____ Bleeding abnormally	_____ Blood Disease
_____ Cancer	_____ Chemical Dependency	_____ Chemotherapy	_____ Circulatory Problems
_____ Cough,persistant	_____ Cortisone treatments	_____ Diabetes	_____ Emphysema
_____ Epilepsy	_____ Fainting or dizziness	_____ Glaucoma	_____ Headaches
_____ Heart murmur	_____ Heart problems	_____ Hepatitis	_____ Herpes
_____ Jaundice	_____ High blood pressure	_____ Jaw Pain	_____ Kidney Disease
_____ Liver Disease	_____ Low blood pressure	_____ Mitral Valve Prolapse	_____ Nervous problems
_____ Pacemaker	_____ Psychiatric care	_____ Radiation treatment	_____ Respiratory Disease
_____ Scarlet Fever	_____ Rheumatic Fever	_____ Shortness of breath	_____ Sinus trouble
_____ Skin rash	_____ Special diet	_____ Stroke	_____ Swollen feet
_____ Tonsillitis	_____ Swollen neck glands	_____ Thyroid problems	_____ Tuberculosis
_____ Tumor/growth	_____ Ulcer	_____ Venereal disease	_____ Weight loss

Medications

List any medications you are currently taking

____

____

List any allergies

____

____

HIPAA Privacy Statement, Assignment and Release

I certify that I, and or my dependents, have insurance coverage and assign directly to Paglia Family Dental all insurance benefits, if any, otherwise to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Paglia Family Dental may use my healthcare information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I read the Notice of Privacy and acknowledge that I have been fully informed of all my rights.
Signature of Patient, Parent or Guardian____Date______________

Please print name____

Doctor's signature____ Date______________