PATIENT REGISTRATION

PATIENT INFORMATION

Name: Last	First	Middle	Preferred Name	Today's Date
Birthday	Minor ❑ yes ❑ no		Spouse, Parent, or Guardian's Name	
Home Address		City	State	Zip
Phone number you can be reached at during the day:			Evening phone number:	
Social Security Number (if patient is over age 18)			**How did you hear about our office?**	

ACCOUNT INFORMATION

Person responsible for account:	Name	Relationship to patient self _________ other _________
Employer	Work Phone	Occupation

INSURANCE INFORMATION

Primary Dental Insurance ❑ yes ❑ no	Secondary Dental Insurance ❑ yes ❑ no
Individual who carries insurance policy (employee)	Individual who carries insurance policy (employee)
Insurance company name	Insurance company name
Employee social security number	Employee social security number
Employee date of birth	Employee date of birth

EMERGENCY INFORMATION

Person to contact:	Name	Telephone number	
Address	City	State	Zip

DENTAL HISTORY

What prompted you to seek dental care at this time? ______________________________

Last dental visit? ____________________ Purpose? ____________________

Has fear of discomfort kept you from regular visits? ❑ yes ❑ no Do you like your smile? ❑ yes ❑ no

How would you describe your present dental health? ❑ excellent ❑ good ❑ fair ❑ poor

Do you clench or grind your teeth? ❑ yes ❑ no Are your teeth sensitive to: ❑ hot ❑ cold ❑ pressure ❑ sweets

Do your gums ever bleed? ❑ yes ❑ no Are you troubled with bad breath? ❑ yes ❑ no

CONTACT & APPOINTMENT CONFIRMATION (we confirm appointments via text message or email)

Daytime phone number: (circle: home cell) Email address:

MEDICAL HISTORY

Have you been a patient in a hospital or emergency room during the past year? ☐ yes ☐ no Reason: ____________

Are you now or have been under the care of a physician during the past 5 years? ☐ yes ☐ no Reason: ____________

Are you allergic or sensitive to any medicines, drugs, or latex products? ____________

Have you ever had any excessive bleeding requiring special treatment? ☐ yes ☐ no

Do you currently: Smoke? ☐ yes ☐ no Drink alcohol? ☐ yes ☐ no Use recreational drugs? ☐ yes ☐ no

What medications are you currently taking (please provide a list if many)? ____________

____

Primary Care Physician Information:

Doctor/Office: ____________ Last visit: ____________ Last physical: ____________

Address: ____________ Phone: ____________

Indicate which of the following you have had or have at present. Please circle "yes" or "no" to each item.

Condition			Condition			Condition		
Allergies / Asthma	yes	no	Heart murmur	yes	no	Scarlet fever	yes	no
Anemia / Sickle cell disease	yes	no	Heart pacemaker	yes	no	Sinus trouble / Hay fever	yes	no
Artificial heart valve	yes	no	Heart surgery	yes	no	Stroke	yes	no
Artificial joints (hip, knee, etc.)	yes	no	Heart trouble	yes	no	Thyroid problems	yes	no
Blood transfusion	yes	no	Hepatitis / Liver trouble	yes	no	Tuberculosis	yes	no
Bruise easily	yes	no	High blood pressure	yes	no	Venereal disease	yes	no
Cortisone medicine	yes	no	HIV positive / AIDS	yes	no	Other conditions: ____________		
Diabetes	yes	no	Kidney disease	yes	no	____________		
Drug / Alcohol addiction	yes	no	Mitral valve prolapse	yes	no	**Women only:**		
Epilepsy / Seizures	yes	no	Osteoporosis	yes	no	Are you pregnant?	yes	no
Fainting / Dizzy spells	yes	no	Psychiatric treatment	yes	no	Due date: ____________		
Glaucoma	yes	no	Radiation / Chemotherapy	yes	no	Are you taking birth control pills?	yes	no
Heart disease or attack	yes	no	Rheumatic fever	yes	no	Are you taking hormones?	yes	no

INFORMED CONSENT

1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent the doctor choose and employ such assistance as deemed fit to provide recommended treatment. Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incapable.

ASSIGNMENT AND RELEASE

I hereby assign directly to Premier Smiles, Ron Katyal DDS. all 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 authorize the use of this signature on all my insurance submissions whether manual or electronic, and agree to any broken appointment or cancellation charges that I may incur unless 24 hours notice is given. I have read/received Dr. Katyal's Notice of Privacy Practices explaining uses and disclosures of protected health information.

Date ____________ Signature ____________