

# *Denzler Family Dentistry*

## *Welcome*

### PATIENT REGISTRATION

Name		
Mailing Address		
City	State	Zip
Email Address		
Home Phone		
Cell Phone		
Work Phone		
Birthdate	Social Security #	
Employer		
Employer Address		
Employer Phone		
Gender M <input type="checkbox"/> F <input type="checkbox"/>		
Status S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Other <input type="checkbox"/>		

### RESPONSIBLE PARTY / INSURED PERSON

Name ( if different from above)	
Mailing Address	
Daytime Phone	
Alternate Phone	
Employer	
Employer Address	
Gender M <input type="checkbox"/> F <input type="checkbox"/>	
Birthdate	Social Security #

### Insurance Information

Insurance Carrier Name	
Claims Address	
Group #	Member ID #
Relationship to Patient Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other <input type="checkbox"/>	

Person to contact in case of emergency Name \_\_\_\_\_

Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Do others in your family come here? \_\_\_\_\_

Who may we thank for referring you to our office?

Another Patient/Friend \_\_\_\_\_

Lincoln Area Telephone Book

Drive by / Sign

My Insurance Company

By My Doctor \_\_\_\_\_

Other \_\_\_\_\_

# Denzler Family Dentistry

## MEDICAL/DENTAL HISTORY

Patient Name \_\_\_\_\_

1. Have you been under the care of a medical doctor during the last two years?

No

Yes  describe \_\_\_\_\_

Physician's Name/Number \_\_\_\_\_

2. Are you currently taking any prescription medications?

No  Yes  List: \_\_\_\_\_

3. Do you have problems/allergies with any medications?

No  Yes  List: \_\_\_\_\_

4. Have you ever taken any diet medications? (Prescribed or Over the Counter)

No  Yes  List: \_\_\_\_\_

5. Have you had or do you currently have any of the following conditions/diseases?

	Y	N		Y	N		Y	N
Allergies (Seasonal)			Fibromyalgia			Nervous Disorders		
Allergy (Latex)			Glaucoma			Neurological Disorders		
Anemia			Head Injuries			Pacemaker		
Arthritis			Heart Attack/Surgery			Psychological Care		
Artificial Heart Valve			Heart Disease/CHF			Radiation Treatment		
Artificial Joints			Heart Murmur			Respiratory Problems		
Asthma			Hemophilia			Rheumatic Fever		
Blood Disease			High Blood Pressure			Rheumatism		
Bruise Easily			HIV/AIDS			Swollen Ankles		
Cancer/Tumor			Hepatitis Type _____			Sinus Problems		
Chronic Cough			Jaundice			Stomach Problems		
Diabetes			Kidney Disease			Thyroid Problems		
Dizziness/Fainting			Liver Disease			Tuberculosis		
Epilepsy/Siezuers			Mental Disorders			STD		
Excessive Bleeding			M V P			Other		

Describe any conditions NOT listed on this form? \_\_\_\_\_

6. What is your chief dental concern? \_\_\_\_\_

Date of last dental cleaning? \_\_\_\_\_. Were x-rays taken Yes  No

Name/phone of last dentist \_\_\_\_\_

7. Have you ever had any of the following

- Trauma to head or teeth       Orthodontic Treatment/Braces  
 Periodontal Treatment/Gum Surgery  
 Oral Surgery       TMJ/ clicking, popping       Headaches/neck pain  
 Difficulty in chewing

8. Does dental work make you nervous? Yes  No

9. Are you satisfied with the appearance of your teeth? Yes  No

10. Do your gums bleed while flossing? Yes  No

11. **Women Only:** Are you pregnant? No  Yes  How many months? \_\_\_\_\_

Are you nursing a child? No  Yes

Provider/Dentist Signature \_\_\_\_\_

Date \_\_\_\_\_

# *Denzler Family Dentistry*

In order to provide greater safety to you and our staff in treating your dental needs, the information needs to be accurate and complete. I have answered all questions fully and to the best of my knowledge. If other health issues arise in the future, I will inform the doctor or staff of these changes.

I authorize any doctor or staff to take x-rays, diagnostic models, photographs and other diagnostic aids deemed appropriate to make a diagnosis of the patient's needs. I authorize the doctors and staff to release information for the purposes of diagnosis, treatment, medical evaluation, peer review, educational purposes, billing of charges, legal and collection actions.

I authorize the doctors or staff to perform all mutually agreeable treatments utilizing such assistance as the doctor deems necessary.

I agree to the use of anesthetics or other medications as necessary for my treatment. I fully understand that using medications has certain risks; a full recital of which will be presented if requested.

I understand that I am responsible for all charges incurred for my treatment or for the patient for whom I am the responsible party regardless of any insurance coverage. Estimated patient portion or "co-payment" is due at the time service is rendered. A finance charge of 1.5% may be added to any balance remaining over 120 days.

Please indicate your preferred method of payment:  
(you may choose more than one)

- Cash
- Check
- Credit Card
- Capital One (DFP) Monthly payments

## **Privacy Notice**

I have read this office's Notice of Privacy Practices, a copy of which I may have for my records upon request. (available our website [www.mylincolndentist.com](http://www.mylincolndentist.com).)

## **Dental Materials Notice**

I have reviewed the State of California DENTAL MATERIALS FACT SHEET as required by law. (available on the website [www.mylincolndentist.com](http://www.mylincolndentist.com).)

Date \_\_\_\_\_

Patient Name (Print) \_\_\_\_\_

Patient Signature \_\_\_\_\_

(or Legal Guardian if patient is minor)