

Frederick W. Arnold D.D.S. P.C.



**PATIENT REGISTRATION & HEALTH REVIEW**

*In order to serve you properly, it is necessary for us to obtain the following information and maintain its currency. All information is strictly confidential and HIPAA compliant.*

**PATIENT INFORMATION**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Prefers to be called \_\_\_\_\_

Male  Female Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_

Business Address \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Spouse/partner name \_\_\_\_\_ Phone \_\_\_\_\_

In the event of an emergency, whom shall we contact? \_\_\_\_\_ Phone \_\_\_\_\_

**ACCOUNT INFORMATION**

I UNDERSTAND FREDERICK W. ARNOLD D.D.S. IS AN INDEPENDENT PROVIDER AND THAT FULL PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED UNLESS ARRANGEMENTS FOR CREDIT ARE MADE IN ADVANCE. CHARGES NOT PAID AT THE TIME OF SERVICE ARE SUBJECT TO A SERVICE FEE. ESTIMATES ARE VALID FOR A PERIOD OF SIX MONTHS FROM THE DATE OF EXAMINATION.

I AGREE TO INFORM YOUR OFFICE OF ANY CHANGES AT EACH APPOINTMENT. I ALSO AGREE TO PROVIDE A MINIMUM OF 48 HOURS NOTICE TO CANCEL OR CHANGE AN APPOINTMENT. FAILURE TO DO SO COULD RESULT IN A CANCELLATION FEE AND DISMISSAL FROM THE PRACTICE. MY SIGNATURE BELOW VERIFIES THAT I HAVE READ AND UNDERSTOOD THE ABOVE.

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

IF YOU ARE COVERED BY DENTAL INSURANCE, ALL OF THE FOLLOWING FIELDS ARE REQUIRED

Name of Dental Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_

Billing address for dental claims (check your employee handbook or card) \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber Birth date \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Relation to patient \_\_\_\_\_

Additional Insurance?  No  Yes \_\_\_\_\_

Name: \_\_\_\_\_

## DENTAL REVIEW

PLEASE CHECK WHETHER OR NOT YOU ARE CURRENTLY EXPERIENCING:

YES NO

- Bleeding gums
- Sore gums
- Receding gums
- Bad breath
- Unpleasant taste
- Burning tongue or lips
- Oral blisters
- Canker sores
- Cold sores

YES NO

- Oral swelling
- Lumps in mouth
- Biting cheeks or lips
- Jaw pain
- Jaw click
- Jaw pop
- Headaches
- Earaches or dizziness
- Difficulty opening/closing jaw

YES NO

- Clenching teeth
- Grinding teeth
- Loose teeth
- Shift in bite
- Food impaction
- Sensitive to hot
- Sensitive to cold
- Sensitive to sweets
- Sensitive to pressure

1. Reason for appointment \_\_\_\_\_  
\_\_\_\_\_
  2. Previous dentist \_\_\_\_\_ City/State \_\_\_\_\_
  3. Date last seen by dentist \_\_\_\_\_ for \_\_\_\_\_
  4. Type of brush \_\_\_\_\_ How often do you brush \_\_\_\_\_
  5. Type of floss \_\_\_\_\_ How often do you floss \_\_\_\_\_
  6. Check if you use  Mouthwash  Fluoride Rinse  Automatic Toothbrush  Water-jet  Other \_\_\_\_\_
  7. If you have ever been treated for periodontal disease, please indicate when \_\_\_\_\_
  8. What goals do you have for your oral health \_\_\_\_\_  
\_\_\_\_\_
  9. Does dental treatment make you  slightly  moderately  extremely  not nervous \_\_\_\_\_
  10. Is your mouth  very comfortable  moderately comfortable  uncomfortable \_\_\_\_\_  
Discomfort at this time is \_\_\_\_\_
  11. Rate your dental health on a scale of 1-10: 1 being devastated and 10 being excellent \_\_\_\_\_
  12. How do you feel about the appearance of your mouth \_\_\_\_\_  
\_\_\_\_\_
  13. Describe any serious complications associated with previous dentistry \_\_\_\_\_  
\_\_\_\_\_
- Any questions about dentistry or oral health you would like addressed \_\_\_\_\_  
\_\_\_\_\_

# HEALTH REVIEW

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Physician's Name \_\_\_\_\_ and Phone \_\_\_\_\_

Date of last physical \_\_\_\_\_ Last Blood Pressure \_\_\_\_\_ Current Weight \_\_\_\_\_

Allergies \_\_\_\_\_

Current medications \_\_\_\_\_

*If your medications change regularly or do not fit in the space provided, please attach a current copy to this form.*

## PLEASE CHECK ONE: NON-APPLICABLE, PRESENTLY EXPERIENCING, OR PREVIOUSLY (PAST) EXPERIENCED

N/A	Pres	Past		N/A	Pres	Past		N/A	Pres	Past	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

YES NO

Have you ever been advised by your physician to take an antibiotic (pre-med) prior to dental treatment?

If yes, antibiotic name \_\_\_\_\_ and method \_\_\_\_\_

Pharmacy of preference \_\_\_\_\_ Phone # \_\_\_\_\_

Women, are you pregnant, nursing, or taking birth control pills? \_\_\_\_\_

Describe any allergic or negative reactions to any medications or substances used in a dental office \_\_\_\_\_

List any conditions, problems, or diseases not listed above \_\_\_\_\_

TO THE BEST OF MY KNOWLEDGE ALL THE PRECEEDING ANSWERS ARE TRUE AND CORRECT. I WILL INFORM YOUR OFFICE OF ANY CHANGES TO THE ABOVE INFORMATION AT EACH APPOINTMENT.

Signed: \_\_\_\_\_

***The next page is for in office use only. Thank you for being thorough.***

# TMJ/TMD REVIEW

Name: _____	Date: _____
-------------	-------------

## PLEASE CHECK WHETHER OR NOT YOU ARE CURRENTLY EXPERIENCING:

- |  |   |   |
|--|---|---|
| YES NO   | YES NO  | YES NO  |
| <input type="checkbox"/> <input type="checkbox"/> Jaw pain                       | <input type="checkbox"/> <input type="checkbox"/> Jaw click           | <input type="checkbox"/> <input type="checkbox"/> Jaw pop           |
| <input type="checkbox"/> <input type="checkbox"/> Clenching teeth                | <input type="checkbox"/> <input type="checkbox"/> Grinding teeth      | <input type="checkbox"/> <input type="checkbox"/> Loose teeth       |
| <input type="checkbox"/> <input type="checkbox"/> Headaches                      | <input type="checkbox"/> <input type="checkbox"/> Facial muscle aches | <input type="checkbox"/> <input type="checkbox"/> Neck muscle aches |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty opening/closing jaw | <input type="checkbox"/> <input type="checkbox"/> Teeth crashing      | <input type="checkbox"/> <input type="checkbox"/> Shift in bite     |
| <input type="checkbox"/> <input type="checkbox"/> Earaches                       | <input type="checkbox"/> <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> <input type="checkbox"/> Dizziness         |

1. Specific Concern \_\_\_\_\_

2. Describe symptoms \_\_\_\_\_

3. Describe history of condition \_\_\_\_\_

4. Previously seen for this condition by Provider	Phone	Dates of Service
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Any previous diagnosis \_\_\_\_\_

6. Incident that may have preceded condition \_\_\_\_\_

7. Does your jaw  get stuck  locked  go out  other \_\_\_\_\_

8. Describe noises in your jaw joint \_\_\_\_\_

9. Do your jaws regularly feel  stiff  tight  tired  other \_\_\_\_\_

10. Describe any recent changes in your bite \_\_\_\_\_

11. Have you previously been treated for any unexplained facial pain or jaw joint problem? \_\_\_\_\_

12. List and date all injuries/incidents/traumas involving the head, neck, face, teeth, or jaw \_\_\_\_\_