FOREST CREEK FAMILY DENTAL CARE
Jeremiah J. Frasier D.D.S., P.C.

PATIENT REGISTRATION & CONSENT FOR TREATMENT

Welcome to Forest Creek Family Dental Care! We are committed to helping you take the best possible care of your smile and your general health. We appreciate you taking the time to complete this information as thoroughly as possible. All of the information you give us is completely confidential and will only be used to provide accurate and complete care for you.

(Please print)

PATIENT INFORMATION						
Patient's Legal Last name:	First:	Middle:	❑ Dr. ❑ Mr.	❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow	
Any nickname or preferred name?	(Maiden name):		Birth date: / /		Sex: ❑ M ❑ F	
Street address:	City:		State:		ZIP Code:	
PLEASE CHECK THE PHONE NUMBER THAT IS THE BEST TO REACH YOU DURING NORMAL BUSINESS HOURS						
❑ Home phone:	❑ Cell phone:		❑ Work phone:			
Social Security Number:	Email address:					
Occupation:	Employer:		Employer phone no.:			
Referred to our office by (please check one box):	❑ Family	❑ Friend	❑ Location	❑ Website	❑ Yellow Pages	❑ Other
Name(s) of friends or family members seen here:						

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Is this patient covered by insurance? ❑Yes ❑ No					
Please indicate primary insurance company:	Subscriber's name:				
Subscriber's Address:	Subscriber's Phone:				
Subscriber's social security #:	Date of birth:	Group number:	Policy number:	Employer name:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Please indicate secondary insurance (if applicable):	Subscriber's name:				
Subscriber's Address:	Subscriber's Phone:				
Subscriber's social security #:	Date of birth:	Group number:	Policy number:	Employer name:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

DENTAL HEALTH HISTORY						
What is the reason for your visit today?						
Do you currently have any dental problems or pain? If so, please describe.						
How do you feel about your current dental health? ❑Excellent ❑ Good ❑Okay ❑ Needs Improvement						
How often do you have dental exams?						
How often do you brush your teeth?			How often do you floss? (Be honest)			
Do you use an electric toothbrush? ❑Yes ❑ No What brand of brush?			Do your gums bleed when you brush or floss? ❑ Yes ❑ No Where?			
Do you use a fluoride rinse? ❑ Yes ❑ No			Do you have areas where food gets caught or floss shreds? ❑ Yes ❑ No Where?			
Have you ever been told to take antibiotics before having any dental care completed?						
Date of last dental exam:	Date of last cleaning:		Date of last x-rays:			
Name of previous dentist/office:	City & State:		Phone #:			
What was done at your last dental visit?						
Are you satisfied with the overall appearance of your teeth and smile?						
Would you like to have whiter teeth? ❑ Yes ❑ No			Have you used whitening products before? ❑ At home ❑ At dental office If so, what kind?			
Would you like to have straighter teeth? ❑ Yes ❑ No			Do you have concerns about your breath? ❑ Yes ❑ No			
Do you feel nervous about having dental treatment? ❑ Yes ❑ No If so, what are your concerns?						
Have you ever had an upsetting dental experience? ❑ Yes ❑ No If so, please describe:						

Have you ever had:				***Are your teeth sensitive to any of the following:***		
Teeth removed	❑ yes	❑ no		Hot or cold	❑ yes	❑ no
Braces or other orthodontic treatment	❑ yes	❑ no		Sweets	❑ yes	❑ no
Were you happy with the results?	❑ yes	❑ no		Biting or chewing	❑ yes	❑ no
Periodontal treatment	❑ yes	❑ no		Cold sores, blisters, or other oral lesions	❑ yes	❑ no
Adjustment of your bite	❑ yes	❑ no		Mouth odors or bad tastes	❑ yes	❑ no
Worn a mouth guard or appliance	❑ yes	❑ no		Painful or bleeding gums	❑ yes	❑ no
Injury to head, face, jaw or mouth	❑ yes	❑ no		Do any teeth feel loose	❑ yes	❑ no
Do you:						
Grind or clench your teeth	❑ yes	❑ no		Notice a change in your bite	❑ yes	❑ no
Bite your lips or cheek	❑ yes	❑ no		Have difficulty in chewing	❑ yes	❑ no
Chew ice, pen caps or anything else	❑ yes	❑ no		Have difficulty in opening or closing your mouth	❑ yes	❑ no
Snore or have other sleeping disorders	❑ yes	❑ no		Clicking or popping of your jaw	❑ yes	❑ no
Smoke or use other tobacco products	❑ yes	❑ no		Have pain in your jaw joints	❑ yes	❑ no
Have headaches, neck aches or shoulder aches	❑ yes	❑ no		Hear ringing in your ears	❑ yes	❑ no

MEDICAL HEALTH HISTORY

How do you feel about your general health? ❑Excellent ❑ Good ❑Okay ❑ Needs Improvement

Briefly describe your diet and daily fluid consumption:

Physician's Name:	Phone #:

Have you been a hospitalized in the past 5 years? ❑Yes ❑ No
If so, what for?

Are you currently being treated for any medical conditions? ❑ Yes ❑ No
If so, please describe:

Are you currently taking medications? ❑ Yes ❑ No Tell us about any prescriptions and over the counter medicines you take below:

Name	***Reason***	***How many times a day is this taken?***	***How long have you been taking this?***

Do you take vitamins, supplements or herbal remedies of any kind? ❑ Yes ❑ No If so, please describe below:

Name	***Reason***	***How many times a day is this taken?***	***How long have you been taking this?***

Are you allergic to, or have you had an adverse reaction, to any of the following items? Please give us details and as much information as possible.

			Name of substance	**Reaction**
Antibiotics	❑ yes	❑ no		
Aspirin, Advil, or other anti-inflammatory drugs	❑ yes	❑ no		
Base metals (ex. nickel, lead, etc.)	❑ yes	❑ no		
Codeine, Vicodine or other pain medications	❑ yes	❑ no		
Dental Anesthetics or "Numbing"	❑ yes	❑ no		
Dental Materials	❑ yes	❑ no		
Fluoride	❑ yes	❑ no		
Latex or Latex sensitive	❑ yes	❑ no		
Other	❑ yes	❑ no		

Have you ever had any of the following:		
❑ Abnormal Bleeding (prolonged)	❑ Dizziness / Fainting Spells	❑ Mitral Valve Prolapse
❑ Anemia	❑ Emphysema	❑ Neurological Disorders
❑ Arthritis	❑ Epilepsy / Seizures	❑ Radiation Therapy
❑ Artificial Heart Valve / Pacemaker	❑ Glaucoma	❑ Respiratory Problems
❑ Artificial Joints (hips, knee, etc.)	❑ Growths	❑ Rheumatic Fever
❑ Anxiety	❑ Hay Fever / Seasonal Allergies / Hives	❑ Severe Headaches
❑ Asthma	❑ Head Injuries	❑ Sickle Cell Disease
❑ Blood Disorder or Disease	❑ Heart (Surgery, Disease, Attack)	❑ Sinus Problems
❑ Blood Transfusion	❑ Heart Murmur	❑ Sleep Apnea
❑ Bruise Easily	❑ Hemophilia	❑ Stroke
❑ Cancer	❑ Hepatitis A B C (please circle)	❑ Thyroid Problems
❑ Chemotherapy	❑ High / Low Blood Pressure	❑ Tuberculosis
❑ Cold Sores / Fever Blisters	❑ HIV+ / AIDS	❑ Tumors
❑ Congenital Heart Disease	❑ Kidney Problems	❑ Ulcers
❑ Cortisone Medicine	❑ Liver Disease	❑ Unexplained Weight Gain or Loss
❑ Diabetes	❑ Mental Disorders	❑ Venereal Disease
❑ Diet (Special or Restricted)	❑ OTHER	

Do you have or have you had any disease, condition or problem not listed above? If so please describe:

FOR WOMEN ONLY					
Are you pregnant?	❑ yes	❑ no	Do you take birth control pills?	❑ yes	❑ no
Are you nursing?	❑ yes	❑ no	Are you transitioning into menopause?	❑ yes	❑ no

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Frasier or his designated staff to take x-rays, study models, photographs, and other diagnostic aides deemed appropriate by doctor to make a thorough diagnosis of patient's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to perform proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure or any oral, written or electronic health records that are identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have read and answered all the questions to the best of my ability. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

6. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dental practice. I understand that I am financially responsible for any balance. I also authorize Forest Creek Family Dental Care and Dr. Jeremiah J. Frasier and/or my insurance company to release any information required to process my insurance claims.

Patient/Guardian signature (If guardian, state your relationship to patient)

Date