PATIENT MEDICAL HISTORY

Patient's Name:	Today's Date:

Address:	Email Address:

City, State, Zip:	Birth Date:	Soc. Security No.	Marital Status

Home Phone:	Work Phone:	Cell Phone:

Physician Name:	Physician Phone:	Date of Last Exam:

Pharmacy:	Pharmacy Phone:

Sex: ☐

If female, please answer the following:

Y N
- ☐☐ Are you taking Birth Control Pills?
- ☐☐ Are you pregnant? If Yes, # of weeks ☐
- ☐☐ Are you nursing?

Please answer the following:

Y N
- ☐☐ Do you smoke or use tobacco?

For Office Use Only

BP: ☐ Heart Rate: ☐

Y N	Conditions
☐☐	High Blood Pressure
☐☐	Low Blood Pressure
☐☐	Heart Attack
☐☐	Angina Pectoris
☐☐	Pace Maker
☐☐	Stroke
☐☐	Mitral Valve Prolapse
☐☐	Artificial Heart Valve
☐☐	Congenital Heart Defect
☐☐	Heart Murmur
☐☐	Rheumatic Fever
☐☐	Heart Surgery
☐☐	Swollen Ankles
☐☐	Fainting Spells
☐☐	Seizures
☐☐	Epilepsy
☐☐	Asthma
☐☐	Emphysema
☐☐	Difficulty Breathing
☐☐	Diabetes
☐☐	Kidney Problems
☐☐	HIV+ AIDS

Y N	Conditions
☐☐	Thyroid Problems
☐☐	Anemia
☐☐	Abnormal Bleeding
☐☐	Blood Transfusion
☐☐	Hemophilia
☐☐	Sickle Cell Disease
☐☐	Cancer – Chemotherapy
☐☐	Radiation Therapy
☐☐	Leukemia
☐☐	Joint Replacement Or Implant
☐☐	Arthritis
☐☐	Yellow Jaundice
☐☐	Hepatitis
☐☐	Venereal Disease
☐☐	Ulcers
☐☐	Colitis
☐☐	Liver Disease
☐☐	Allergies
☐☐	Hay Fever
☐☐	Tuberculosis
☐☐	Glaucoma
☐☐	Fever Blisters

Y N	Conditions
☐☐	Frequent Headaches
☐☐	Psychiatric Problems
☐☐	Alcohol Abuse
☐☐	Drug Abuse
☐☐	Sinus Problems
☐☐	Premedication Needed
☐☐	Other ______________________________

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Y N	Allergies
☐☐	Aspirin
☐☐	Codeine
☐☐	Dental Anesthetics
☐☐	Erythromycin
☐☐	Jewelry
☐☐	Latex
☐☐	Metals
☐☐	Penicillin
☐☐	Tetracycline
☐☐	Other ______________________________

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Medications:

Previous Hospital Stays or Surgeries:

PATIENT DENTAL HISTORY

Patient's Name: **Today's Date:**

Y	N	Question
☐	☐	Do your gums bleed while brushing or flossing?
☐	☐	Are your teeth sensitive to hot or cold liquids/food?
☐	☐	Are your teeth sensitive to sweet or sour liquids/food?
☐	☐	Do you feel pain in any of your teeth?
☐	☐	Do you have any sores or lumps in or near your mouth?
☐	☐	Have you had any head, neck, or jaw injuries?
☐	☐	Do you have frequent headaches?
☐	☐	Do you clench or grind your teeth?
☐	☐	Do you bite your lips or cheeks frequently?
☐	☐	Have you ever had any difficult extractions in the past?
☐	☐	Have you had any orthodontic work?
☐	☐	Have you ever had prolonged bleeding following extractions?
☐	☐	Have you ever had instructions on the correct method of brushing and flossing your teeth?
☐	☐	Have you ever had instructions on the care of your gums?

Have you ever experienced any of the following problems in your jaw? (Choose ALL THAT APPLY:)

☐Clicking ☐Pain (Joint, Ear, Side of Face) ☐Difficulty in opening or closing ☐Difficulty in chewing

Y N

☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below…

Signature: (If under 18, Parent or Guardian Signature Required)	Date

MEDICAL HISTORY UPDATE

For Office Use Only:

I have reviewed the Medical History on file. My (or the patient's) health and medications have changed as follows (if no change, write "No Change")

Date ___/___/___

Update

____

____

Signature of Patient (or Guardian)___________________________________

Date ___/___/___

Update ____

____

Signature of Patient (or Guardian)___________________________________

Date ___/___/___

Update____

____

Signature of Patient (or Guardian)_______________________________________

BUCKLIN FAMILY DENTISTRY
PATIENT REGISTRATION FORM
Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for our assistance – we will be happy to help!

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Street address:	Birth date:	Age:	Sex: ❑ M ❑ F

P.O. Box:	City:	State:	Zip Code:	Social Security no.:

Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Where do you prefer calls: H_____ W_____ C_____

Occupation:	Employer:	Employer phone no.: ( )

How did you hear about our office?	❑ Internet	❑ Front Sign	❑ Yellow Pages

❑ Family or Friend:	May we use your name in thanking this person? ❑ Yes ❑ No

Email Address:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here?	❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes ❑ No

Name of primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Subscriber ID no.:	Birth date: / /	Group no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber's S.S. no.:	Group no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Person to contact in case of emergency:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

AUTHORIZATION, RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me by Bucklin Family Dentistry to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of patient or parent if minor _Date_

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Payment in full at each appointment

_________ Cash
_________ Personal Check
_________ Credit Card

_________ Visa _________ MasterCard _________ Care Credit _________ Discover Card
Card # ____ Expiration Date ______________________

LATE CHARGES

Any statement not paid in full 30 days from the date of the statement will be subject to a time price differential of 1.5% per month on the unpaid balance until the unpaid balance is paid in full.

PROFESSIONAL SERVICES

I realize that failure to keep my account current may result in Bucklin Family Dentistry being unable to provide additional dental services except for dental emergencies or when additional services are pre-paid.

COLLECTION

If suit is brought by Bucklin Family Dentistry for payment, the patient agrees to pay all costs in connection with the suit, including reasonable attorney fees, whether or not the suit proceeds to judgment.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.