GARIBALDI CROSSING DENTAL

CONFIDENTIAL PATIENT REGISTRATION

In order to provide the highest quality of dental treatment, please answer the following questions. All the information provided to us will remain confidential.

Last Name: ___________ **First Name:** ___________ **Preferred Name:**___________

Date of Birth (MM/DD/YY): ____/____/_____ **Gender:**______

Address: _________________________ **City:** ____________ **Postal Code:** _______

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** _________

Email: ___________________________ **Preferred Method of Contact: H/C/W/Email**

Emergency Contact: ________________ **Phone Number:** ____________________

Relationship to Patient: _________________

Employer: ________________ **Occupation:** ___________________

How did you hear about us? ______________________________

If the patient is a minor and a custody/guardianship order is in place, please provide details as to which person can provide authorization for dental care:
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CONSENT FOR ELECTRONIC COMMUNICATIONS

Garibaldi Crossing Dental, and our respective contractors on our behalf, may utilize the contact information you have provided to us to send you information including appointment reminders, appointment scheduling and treatment reminders, and promotional messages about other services and products that we may offer. By signing below, you consent to receive non-encrypted emails and text messages and understand the risks. Message and data rates from your cellular carrier may apply for text messages. You may revoke your consent at any time.

Patient or guardian signature: __________________ **Date:** _____________

DENTAL INSURANCE

Please submit insurance information directly to reception. Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this we require your authorization.

I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to this dental practice.

Patient or guardian signature: __________________ Date: _____________

CONFIDENTIAL MEDICAL HISTORY

Physician's name:_______________ Phone: ___________________

1. Are you in good health? Yes ____ No ____ Details: __________________
2. When was the last time you had a medical examination? ______________
3. Are you presently receiving treatment for any **illness**? If yes, please provide details: ____
4. Have you ever been **hospitalized**? If yes, please provide details: ________
5. Do you have a **pacemaker**? Yes ____ No ____
6. Are you subject to prolonged **bleeding**? Yes____ No____
7. Have you ever been advised to take **antibiotic pre-medication** prior to dental treatment? Yes ____ No ____
8. Do you have **allergies** or sensitivities? No___ Seasonal/Hayfever___ Food: ______ Medication:_________ Metals:________ Mint:_______Other: _________________
9. Have you ever had a **reaction** to any kind of medicine or dental local anesthetic? If yes, please specify: ____
10. Are you presently taking any kind of **medication**(s)? No___ If yes, please specify: ____ ____ ____
11. Female patients- Are you **pregnant** or think you might be pregnant? Yes___ No___ Breastfeeding? Yes____ No____

12. Do you **smoke/ use tobacco products**? If yes, how much per day? ____________

13. Do you use any cannabis products? Yes____ No____

14. Do you take any **drugs** including cocaine, crystal meth, amphetamines, opiates or opiate antipsychotics? ___________

15. Do you take anabolic **steroids**, pre workout, fat burners, and/or ephedrine? _________________________

16. Do you take Viagra, Cialis, or other libido enhancement medication? Yes___ No___

Please indicate below (√) if you **presently have** or **have ever had any** of the following:

AIDS/HIV	**Eating disorders**	**Kidney disease**	**Rheumatic fever**
Artificial joints/ valves	**Epilepsy/seizures**	**Liver disease (hepatitis/jaundice)**	**Stomach ulcer/ digestive problems**
Asthma	**Heart Disease/heart murmur**	**Lung disease**	**Stroke**
Cancer: radiation/ chemotherapy	**High/low blood pressure**	**Mental or nervous disorder**	**Tuberculosis**
Diabetes Type I or II	**Hyper/hypoglycemia**	**Osteoporosis**	**Venereal/ communicable disease**

Please list any additional information related to your health that has not been addressed:

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CONFIDENTIAL DENTAL HISTORY

1. When was your last dental visit? _____________ Previous dentist: ______________
2. Do you clench or grind your teeth? Yes____ No____
3. How often do you brush your teeth? _____________ Floss? ________________
4. Do you have sensitive teeth? Yes____ No _____
5. Have you ever had orthodontic treatment? Yes____ No____
6. On a scale of 1-10, what is your level of dental anxiety? _______
7. What is your main reason for today's visit? _________________________________

Patient or Guardian Signature: ____________________Date: ___________________