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1840 Madison Avenue
Council Bluffs, IA 51503
(712) 328-1100
Caring Dentistry for Adults and Children

Patient Registration

Thank you for selecting our office to provide dental care for you. Please answer the following questions:

PLEASE PRINT Date_____

Patient Name _____ Birth date_____ Sex M F

Address _____ City _____ E-mail _____

State _____ Zip _____ Phone _____ Cell Phone _____

IF IN COLLEGE: Name/Address of college _____ Full-time? Y N

Employer _____ On disability? Y N Social Security No. _____

Employer's Address _____ Work Phone _____

Circle: Single Widowed Divorced Married

Spouse's name (parent/guardian if child) _____ Birth date _____

Phone (if different than above)_____ Address _____

Social Security No._____ Employer _____

Whom may we thank for referring you to our office? _____

Whom may we contact in case of an emergency? _____ Phone_____

If covered by dental insurance complete the following OR HAVE US COPY YOUR INSURANCE CARD:

Insurance company _____ Group No._____

Insurance company phone # _____

Insurance company address _____

Name of person insurance is through _____ Social Security No._____

Employer _____ Address _____ Birth date_____

(If Medicaid) Case worker's name _____ Phone _____

If patient also has coverage through an additional plan please complete:

Insurance company_____ Group No. _____

Insurance company address_____

Name of person insurance is through_____ Social Security No._____

Employer _____ Address _____ Birth date _____

PLEASE READ AND SIGN IN THE SPACE PROVIDED: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorized release of any information relating to this claim. I hereby authorize payment of the dental benefits otherwise payable to me directly to this dental office. I authorize examination and taking of diagnostic x-rays on myself and dependent children.

The parent or guardian bringing a child to the appointment is responsible for financial arrangements.

Primary reason for this appointment: ☐ Full exam/cleaning teeth ☐ Correction of a specific concern

Dental History:

Please Circle:

Do your gums ever bleed when you brush your teeth? ---------- YES NO

Do you clench or grind your teeth? ---------- YES NO

Do you ever have clicking, popping, or discomfort in the jaw joints (TMJ)? ---------- YES NO

Have you ever had orthodontic treatment (treatment to straighten teeth)? ---------- YES NO

Have you ever had a bad experience in a dental office? ---------- YES NO

About when last have you had dental x-rays? Where were they taken?

Are any teeth sensitive to (please circle): Hot Cold Sweets Pressure

If you have a specific dental problem that concerns you please describe it.

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Anytime ☐ Mon ☐ Tue ☐ Wed ☐ Thur

Medical History:

Your physician's name: _____

Do you consider yourself to be in general good health at this time? ---------- YES NO

Have you ever had a bad reaction to Novocaine-type anesthetics? ---------- YES NO

Have you ever had any problems with bleeding after cuts, tooth extractions, etc.? - - YES NO

(Women) Are you pregnant? ---------- YES NO

Have you ever taken bisphosphonates (e.g., Actonel, Boniva, Fosamax, Didronel, Skelid, Aredia, Zometa, Bonefos) for cancer or osteoporosis? ---------- YES NO

Do you use tobacco products? YES NO (please circle): cigars cigarettes smokeless

If you've been hospitalized within the last two years please explain when and for what:

If you are **allergic** to any medications or substances please list them:

If you are currently undergoing any medical treatment please explain:

Please list any medications (prescription, over-the-counter, or herbals) you are taking:

Please CIRCLE if you have had any of the following:

Heart Trouble	High Blood Pressure	Organ transplant	Latex Allergy
Heart Valve	Pacemaker/Defibrillator	Depression	Blood Disease
Anemia	Stroke/Heart attack	Diabetes	Artificial joints
Tuberculosis	Hepatitis	Hearing impaired	Asthma/Respiratory condition
AIDS	Epilepsy or Seizures	ADD/ADHD	Chemotherapy/Radiation

Please list any other serious illness you have had that is not circled above:

Your signature_____ **Date**_____