Kevin L. Caldwell DDS, PC

Patient Registration

Today's date: _____

How did you hear about our office? TV_____ Website_____ Phonebook_____ Office Sign_____ Other_____
(Please List)

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

PLEASE PRINT AND ANSWER ALL QUESTIONS

PATIENT:_____ Phone: Home_____ Work_____ Cell_____
Last Name First Name MI

Name I prefer to be called: _____ [ ] Male [ ] Female

[ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Address_____ City_____ State_____ Zip Code_____
(If your address is a PO Box please include a physical address as well.)

Birth date____/____/____ Age: ____ Social Security No._____-_____-_____ Best time to call: _____

Best phone number to confirm all appointments: _____

E-Mail:_____ Employer:_____ Occupation:_____

Work Address:_____ Work Phone No._____

SPOUSE, PARENT, and or GUARDIAN INFORMATION

Spouse and/or Parent's Name_____ [ ] Mother [ ] Father [ ] Step Mom [ ] Step Dad [ ] Guardian

Spouse and/or Parent's birth date: _____/_____/_____ Age:_____ Spouse and/or Parent's SSN:_____

Spouse and/or Parent's Employer_____ Work number:_____ Ext:_____

Spouse and/or Parent's Occupation: _____ Relationship to patient_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ SSN: _____-_____-_____

Birth date: ____/____/____ Phone: Home_____ Work _____ Cell _____

Patient's Previous Dentist_____ Last visit date_____

DENTAL INSURANCE:

Insurance Name: _____

Address_____

Subscriber's
Name_____Ins ID#_____

Employer_____ DOB:_____

Group#_____ Ins Phone #_____

SECONDARY DENTAL INSURANCE:

Insurance Name:_____

Address_____

Subscriber's
Name_____Ins ID#_____

Employer_____ DOB:_____

Group#_____ Ins Phone #_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING- INDICATE WITH (X)

__Allergies to Drugs
__Allergies to anesthetics
__Cardiovascular disease
__ High blood pressure
__ Neurological problems
__ Radiation treatment

__ Excessive bleeding after Surgery or extractions
__ Rheumatic fever rheumatic heart
__Arthritis
__Epilepsy or seizures

__ Asthma
__ Hay fever or allergies in general
__ Diabetes
__ Kidney problems
__ Liver problems or hepatitis
__ Malignancies (Tumor, cancer)

__Psychiatric care emotional problems
__ Have you ever required a blood transfusion
__ Sinus problems
__Have you ever been treated for alcoholism or drug addiction

__Stroke
__Thyroid disorder
__ Eye disorders
__Tuberculosis
__ Ulcer or colitis
__ Currently pregnant
* how many weeks_____
__ Sexually transmitted disease

__ Occupationally exposed to radiation
__ HIV or Aids
__Lupus

__ Hepatitis (Jaundice) Type A__B__C__D__
__ Herpes
__Heart murmur
__ Angina
__ Artificial joint, hip pacemaker, or implant
__ Respiratory disorder/emphysema
__ Anemia

__Fainting/dizzy spells
__ Mitral valve prolapsed

Are you allergic to any of the following?

Any metal	Yes___ No___	Erythromycin	Yes___ No___	Tetracycline	Yes___ No___
Codeine	Yes___ No___	Latex	Yes___ No___	Other	Yes___ No___
Penicillin	Yes___ No___	Sulfa drugs	Yes___ No___	_____	

Describe any current medical treatment, including drugs; impending operations, pregnancies or other information we should be aware of:

_____

_____

_____

Are you taking drugs for: ___ Heart condition ___ Oral contraceptives ___ High blood pressure ___ Cortisone or steroids
___ Anticoagulants (Blood thinners or aspirin) ___ Sedatives or tranquilizers ___ Other

Current General Medical Physician:_____ Phone:_____

Address:_____

Preferred Pharmacy:_____ Phone:_____

Person to contact in case of emergency_____

Relationship:_____**Phone no:**_____

Address:_____

HOW DO YOU FEEL ABOUT YOUR SMILE

Would you like your teeth whiter? Yes___ No___
Are you concerned with stains on your teeth? Yes___ No___
Do you like your smile? Yes___ No___
How many times a week do you floss?_____
Type of bristles you use? ___ Soft ___ Medium ___ Hard
How long do you use a toothbrush before replacing it? _____ Months

Do you think your teeth are crooked? Yes___ No___
Do you have missing teeth that you would like to replace? Yes___ No___
Do you take an antibiotic before dental treatment? Yes___ No___
How many times a day do you brush your teeth?_____
Do you use an electric toothbrush?_____

I would like more information on :_____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING- INDICATE WITH (X)

___Teeth sensitive to hot, cold, sweets, or pressure
___Bleeding gums, How long?_____
___Food impaction
___Clenching or grinding of teeth
___Burning of tongue
___Oral habits (fingernail, or cheek biting etc.)
___Frequent sores on lips or in mouth
___ADD/ADHD

___ Bad breath
___Unpleasant taste
___ Unfavorable dental experience
___Complications from Extractions
___ Periodontal treatment
___Orthodontic treatment
___Mouth breather
___Handicaps or disabilities

___Tobacco products
___Drink alcohol, How often?_____
___Fluoride supplements, rinses
___TMD treatment (Jaw joint)
___Swelling or lumps in mouth
___Consent to use Nitrous Oxide Sedation
___Pain around ear or jaw
___Hearing impairment

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

CONSENT:

A copy of this consent form will be given upon request

1.) The undersigned hereby authorize Dr. Kevin L. Caldwell or staff to take x-rays, study models, photographs, or any diagnostic aid deemed appropriate by Dr. Kevin L. Caldwell to make a thorough diagnosis of the patient's dental needs.

2.) I also authorize Dr. Kevin L. Caldwell to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication as therapy indicated for such treatment in connections with the above named patient.

3.) I understand that where appropriate permission is given for Dr. Kevin L. Caldwell and staff to send necessary models, x-rays, and health related information to appropriate dental specialists or insurance carriers. This permission will remain in force as long as I am a patient of this dental practice. I also authorize release of photographs or other images for educational publications or presentations.

4.) I understand that all responsibility of payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made. I also agree any amount not covered by my dental benefit plan will be my responsibility to pay in full. In the event payments are not received by the agreed upon dates I understand that a monthly 1.5% rebilling charge will be added to my account in addition to any collection charges.

5.) I understand that my dental benefit plan, if I am insured; is a contract between the insurance company and myself. I also understand that Dr. Kevin L. Caldwell is not a party to that contract; therefore, it is my responsibility to be aware of my dental benefits.

6.) I understand it is my responsibility to advise your office of any changes regarding the information contained on this form.

7.) I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I give consent to the following person(s) for release of patient information and/or records:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient (18 years or older) and/or Legal Guardian's Signature:_____

Date_____