

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 or Parent's Name _____ [] Mother [] Father [] Step Mom [] Step Dad [] Guardian

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

Spouse or Parent's Employer _____ Work number: _____ Ext: _____

Spouse 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 _____

Hobbies _____

DENTAL INSURANCE:

SECONDARY DENTAL INSURANCE:

Insurance Name: _____

Insurance Name: _____

Address _____

Address _____

Subscriber's Name _____ SSN _____

Subscriber's Name _____ SSN _____

Employer _____ DOB: _____

Employer _____ DOB: _____

Group# _____ Ins Phone # _____

Group# _____ Ins Phone # _____

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

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergies to Drugs | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis (Jaundice) |
| <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> Hay fever or allergies in general | <input type="checkbox"/> Thyroid disorder | Type A ___ B ___ C ___ D ___ |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eye disorders | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Liver problems or hepatitis | <input type="checkbox"/> Ulcer or colitis | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Malignancies (Tumor, cancer) | <input type="checkbox"/> Currently pregnant
how many weeks _____ | <input type="checkbox"/> Artificial joint, hip
pacemaker, or implant |
| <input type="checkbox"/> Excessive bleeding after
Surgery or extractions | <input type="checkbox"/> Psychiatric care
emotional problems | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Respiratory
disorder/emphysema |
| <input type="checkbox"/> Rheumatic fever
rheumatic heart | <input type="checkbox"/> Have you ever required
a blood transfusion | <input type="checkbox"/> Occupationally exposed to
radiation | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> HIV or Aids | <input type="checkbox"/> Fainting/dizzy spells |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Have you ever been treated
for alcoholism or drug addiction | <input type="checkbox"/> Lupus | <input type="checkbox"/> 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: _____

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___ Do you think your teeth are crooked? Yes___ No___
Are you concerned with stains on your teeth? Yes___ No___ Do you have missing teeth that you would like to replace? Yes___ No___
Do you like your smile? Yes___ No___ Do you take an antibiotic before dental treatment? Yes___ No___
How many times a week do you floss? _____ How many times a day do you brush your teeth? _____
Type of bristles you use? ___ Soft ___ Medium ___ Hard Do you use an electric toothbrush? _____
How long do you use a toothbrush before replacing it? _____ Months

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	___ Bad breath	___ Tobacco products
___ Bleeding gums, How long? _____	___ Unpleasant taste	___ Drink alcohol, How often? _____
___ Food impaction	___ Unfavorable dental experience	___ Fluoride supplements, rinses
___ Clenching or grinding of teeth	___ Complications from Extractions	___ TMD treatment (Jaw joint)
___ Burning of tongue	___ Periodontal treatment	___ Swelling or lumps in mouth
___ Oral habits (fingernail, or cheek biting etc.)	___ Orthodontic treatment	___ Consent to use Nitrous Oxide Sedation
___ Frequent sores on lips or in mouth	___ Mouth breather	___ Pain around ear or jaw
___ ADD/ADHD	___ Handicaps or disabilities	___ 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.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein.

Initials _____ Date _____

I verbally reviewed the medical/dental information above with the patient named herein.

Initials _____ Date _____

I verbally reviewed the medical/dental information above with the patient named herein.

Initials _____ Date _____

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 or Legal Guardian's Signature _____ **Date** _____