HEISLER & GIANNETTI
FAMILY DENTISTRY

Patient Registration

We thank you for choosing us as your dental provider. To assist us in better serving you, please complete the following forms to the best of your ability. The information provided is important to ensure we treat you in the safest manner possible. If you have any questions, please do not hesitate to ask.

Patient Information

Patient's Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ Social Security #: _____ Sex: M ☐ F ☐ Other ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐ No Comment ☐

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Preferred method of contact: Email ☐ Text ☐ Phone Call ☐

Email Address: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone Number: _____

Employer: _____ Occupation: _____

Are any of your family members our patients? Yes ☐ No ☐ If so, who? _____

How did you hear about us? _____

Previous Dentist's Name: _____ Date of Last Visit: _____

Primary Dental Insurance

Name of Insurance Co: _____ Phone #: _____

Subscriber's Name: _____ DOB: _____ Relationship: _____

Employer's Name: _____ SS #: _____ Subscriber ID: _____

Employer's Address: _____ Group/Contract/Local #: _____

*If you have a **Secondary Dental Insurance**, please let the front desk know.

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other health care professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I understand that I am responsible for all charges if procedures are not covered by insurance, as well as any additional collection costs if this office determines they are necessary. I have reviewed the above information and it is accurate to the best of my knowledge.

X_____ Date: _____

Dental Health History

Answering the following questions will allow your dentist to better treat your individual issues and address the future goals that you have for your mouth and smile.

Reason for seeking care today: Exam ___ Cleaning ___ Pain/Specific problem: ___

Please select yes or no:

Are you having pain/discomfort at this time?	Yes	No
Do your teeth hurt when you chew?	Yes	No
Are your teeth sensitive to hot/cold/sweets?	Yes	No
Do you clench/grind your teeth?	Yes	No
Do you wake up with a sore jaw?	Yes	No
Have you ever had braces?	Yes	No
Have you ever had to pre-medicate for dental treatment in the past?	Yes	No
Are you interested in learning about our teeth whitening?	Yes	No
Are you interested in teeth straightening options?	Yes	No

Is there anything that bothers you about the appearance of your teeth or smile? _____

_____

Please rate how anxious you are about dental treatment (1 - relaxed to 10 - highly anxious) _____

If anxious, is there anything specific that bothers you? _____

Is there anything we can do to make your visit more comfortable (neck pillow, chapstick, music, etc)? _____

_____

Dental Office Informed Consent

At Heisler & Giannetti Family Dentistry we take informed consent very seriously. We strive to explain all treatment options, their advantages and disadvantages, as well as the potential risks for all treatment completed at the office. You as the patient have the final say in what treatment occurs, so we only want you to sign this form when you understand that dental treatment has inherent (though rare) risks associated and all of your questions have been answered.

We make every effort to minimize any risk or complication for all dental treatment performed, but there is always a small risk for complications during treatment. Some generalized complications include but are not limited to sensitivity, swelling, bleeding, and other nerve issues.

I have read, understood, and consent to dental treatment.

X_____ Date: _____

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Medical Health History

Physicians Name: _____ Phone Number: _____

Date of Last Check-up: _____ Height: _____ Weight: _____

Hospitalizations in the past 2 years: _____

Do you use tobacco products? Yes ☐ No ☐ If yes, how much/week? _____

Do you consume alcoholic beverages? Yes ☐ No ☐ If yes, how much/week? _____

Do you use recreational drugs? Yes ☐ No ☐ If yes, what and how much/week? _____

*We ask this for your safety when administering anesthetic only

Please select yes or no for the following conditions/questions:

Heart attack	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Angina	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Artificial Heart Valve	Yes ☐	No ☐	Emphysema	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐	Tuberculous	Yes ☐	No ☐
Congenital Heart Defects	Yes ☐	No ☐	Sinus Issues	Yes ☐	No ☐
Blood Thinners	Yes ☐	No ☐	Kidney Problems	Yes ☐	No ☐
Bleeding Problems	Yes ☐	No ☐	Liver Problems	Yes ☐	No ☐
Sickle Cell Disease	Yes ☐	No ☐	Thyroid Disease	Yes ☐	No ☐
Cancer or Tumors	Yes ☐	No ☐	Epilepsy (seizures)	Yes ☐	No ☐
Chemotherapy/Radiation	Yes ☐	No ☐	Multiple Sclerosis	Yes ☐	No ☐
Hypertension	Yes ☐	No ☐	Herpes	Yes ☐	No ☐
Artificial Joints	Yes ☐	No ☐	Hepatitis (A or B)	Yes ☐	No ☐
Low Blood Pressure	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐
HIV/AIDs	Yes ☐	No ☐	Psychiatric Disease	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Drug Addiction	Yes ☐	No ☐

Please list any conditions you have not listed above: _____

Please list any **ALLERGIES** you have and your reaction: _____

_____

For women only: Are you currently pregnant? ___ Are you nursing? ___

I certify that the above information is correct to the best of my knowledge and understand that withholding health information and/or not updating recent health changes may put me at risk during treatment. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to third party payers and/or health practitioners.

X_____ Date: _____

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List of Current Medications

Medication Name	Dose/Frequency	Condition

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Consents and Office Policy Information

APPOINTMENT CANCELLATION POLICY

When you make an appointment, we reserve that time for you and we do our utmost to be on schedule. Last minute cancellations and missed appointments prevent other patients from being seen who are seeking prompt care. If necessary, please provide our office at least 24 notice if there is a need to reschedule or cancel your appointment. If no notice a given, the office retains the right to charge a fee of $40.

PATIENTS WITHOUT INSURANCE

Patients without insurance coverage are asked to pay for services when rendered. We accept Cash, Check, MasterCard, Visa, Discover, America Express or Debit/ATM cards. We also arrange pre-payments and financing plans as well as offer an In-House membership plan.

CONSENT FOR DENTAL PHOTOGRAPHY

In connection with dental treatment, I consent to allow the option of photographs to be taken before, during, and after completion of my treatment to be used for dental records, communication with the dental lab, referring dentists, and specialists.

X_____ Date: _____

I further agree and consent that the photographs relating to my dental care may be published in professional journals, dental photo albums, digital media or patient counseling. No facial identifying features will be allowed without additional explicit consent.

X_____ Date: _____