Bluff City Dental

Patient Registration Form

Today's Date:

PATIENT INFORMATION

Patient Name:

Social Security no.:	Birth date:	Who may we thank for referring you?

Address: City, State, Zip:

Home phone no.:	Cell phone no.:	Email Address:
Employer:	Employer phone no.	Emergency Contact Name: Emergency Contact Phone:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Policy Holder's name: Employer:	Policy Holder's SSN:	Birth date:	Insurance Carrier: Phone no.:	Group no.: ID no.:

Secondary Insurance (if applicable):

Policy Holder's name: Employer:	Policy Holder's SSN:	Birth date:	Insurance Carrier: Phone no.:	Group no.: ID no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bluff City Dental or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

_____

_____

_____

Comments:

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

BLUFF CITY DENTAL

CONSENT FOR DENTAL TREATEMENT

_____

Patient Name (Please print)

PLEASE READ THIS FORM AND SIGN AT THE BOTTOM

I hereby authorize my dentist, Dr. Phillip Isaacman, and whoever he may designate as his associates, assistants, and/or hygienists, to perform upon me those dental procedures which we have discussed, and I have accepted, in the treatment plan. If any unforeseen condition arises in the course of these designated procedures calling in his further request and authorize the performance of whatever treatments and/or procedures he deems advisable.

I consent to the treatment plan I have accepted after having been advised of alternative plans of treatment that are available.

There are risks associated with any dental treatment. Treatment may include, but is not limited to, performance of all procedures involved in the practice of dentistry, exposure to radiation, the administration of local anesthetic or prescription of anti-anxiety medications, antibiotics, and/or pain medication. Some possible complications include, but are not limited to, the following: post-treatment pressure and temperature sensitivity, pain or throbbing, pulp inflammation, swelling, infection and/or reinfection, injury to adjacent teeth and/or hard or soft tissues, bleeding, failure to wound to heal, dry socket, loss of teeth, incomplete removal of tooth, loss of bone, injury to adjacent structures, instrument breakage, allergic reaction to drugs, bacterial endocarditis, breakage of root(s), death (in extremely rare instances), retained root fragments, swallowing and/or aspiration of objects, failure of treatment to accomplish its purpose, trismus (jaw pain and/or difficulty opening mouth), paresthesia or numbness of tongue and/or face, fracture of the mandible (lower jaw) or maxilla (upper jaw), and any other such or similar complications.

I further consent to the administration of any drugs that may be deemed necessary in my case, including but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes, but is not limited to, the following complications: adverse drug response (e.g. allergic reaction), cardia arrest, thrombophlebitis (e.g. irritation and swelling of a vein), aspiration, pain, discoloration, and injury to blood vessels and/or nerves that may be caused by injections of any medications or drugs.

Additional oral surgery, hospitalization, and/or further treatment may be recommended or required. A more complete explanation of all potential complications is available to me upon my request from Dr. Isaacman.

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

AKNOWLEDGEMENT: I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information it provides. I was given an adequate opportunity to ask questions, and any questions that I asked were answered to my satisfaction.

I hereby authorize my dentist, Dr. Phillip Isaacman, and whoever he may designate as his associates, assistants, and/or hygienists, to perform the requested and/or recommended diagnostic, surgical, and/or dental treatment. This consent form will remain valid unless revoked by me in writing.

_____ _____

Signature of Patient or Guardian **Date** _____

Print name of Patient or Guardian