WILLOW family dental

Whom may we thank for referring you?

How would you like us to contact you regarding appointments?

Email: ☐ Text: ☐ Call: Home ☐ Cell ☐ Work ☐

I would like a text message reminder on my appointment day! Yes ◯ No ◯

Please sign me up for the patient E-Newsletter. Yes ◯ No ◯

Patient Information

Gender: Date:

Title | First | MI | Last | Date of Birth: | Social Security Number: | Driver's License #

Contact Info: Home | Cell | Work | Email Address

Home Address: Street Address | City | State | Zip Code

Employer/ Insurance Information: Employer | Name of Insurance Carrier | Group # | Patient ID#

Spouse/Partner or Parent Information

Title | First | MI | Last | Date of Birth: | Social Security Number: | Driver's License #

Contact Info: Home | Cell | Work | Email Address

Home Address: Street Address | City | State | Zip Code

Employer/ Insurance Information: Employer | Name of Insurance Carrier | Group # | Patient ID#

Emergency Contact

Person to contact in an emergency? | Home Phone | Cell Phone | Relation

Nearest relative not living with you? | Home Phone | Cell Phone | Relation

Dental History Information

Name of Previous Dentist: | City/State | Date of Last Exam | Date of Last Cleaning | Date of Last X-rays | How often do you brush your teeth? | How often do you floss your teeth?

Do you have any of the following:

Bad Breath	Yes ◯ No ◯	Bite Lips/Cheek	Yes ◯ No ◯	Sensitivity to Hot/ Cold/Sweets/Biting	Yes ◯ No ◯
Bleeding Gums	Yes ◯ No ◯	Food Caught Between Teeth	Yes ◯ No ◯	Clicking or Popping in Jaw	Yes ◯ No ◯
Smoke Cigarettes, Pipe or Cigar	Yes ◯ No ◯	Chew Tobacco	Yes ◯ No ◯	Chew on One Side of Mouth	Yes ◯ No ◯

General Health Information

Name of Physician: | Phone Number: | Date of Last Exam

Is your general health in good condition? Yes No

Are you being treated by a physician now? Yes No

Have you ever been hospitalized? Yes No

Do you have or have you had?

Aids/HIV	Yes No	Epilepsy	Yes No	Psychiatric Care	Yes No	Aspirin Allergy	Yes No
Anemia	Yes No	Fainting/ Dizziness	Yes No	Radiation Treatment	Yes No	Barbiturate Allergy	Yes No
Arthritis/Rheumatism	Yes No	Glaucoma	Yes No	Respiratory Disease	Yes No	Codeine Allergy	Yes No
Artificial Heart Valve	Yes No	Headaches	Yes No	Rheumatic/ Scarlet Fever	Yes No	Iodine Allergy	Yes No
Back Problems	Yes No	Heart Murmur	Yes No	Sinus Trouble	Yes No	Latex Allergy	Yes No
Excessive Bleeding	Yes No	Heart Problems	Yes No	Skin Rash	Yes No	Anesthetic	Yes No
Blood Disorder	Yes No	Hepatitis	Yes No	Special Diet	Yes No	Sulfa Allergy	Yes No
Cancer	Yes No	High Blood Pressure	Yes No	Fen-Phen/Diet Drugs	Yes No	Other Allergies	Yes No
Chemical Dependency	Yes No	Jaundice	Yes No	Stroke	Yes No	Penicillin Allergy	Yes No
Chemotherapy	Yes No	Jaw Pain	Yes No	Swollen ankles/ feet	Yes No	Please list all Prescribed or Over the Counter Medications or Vitamins.	
Circulatory Problems	Yes No	Kidney Disease	Yes No	Swollen neck	Yes No		
Congenital Heart Lesions	Yes No	Low Blood Pressure	Yes No	Thyroid Problems	Yes No		
Cortisone Treatments	Yes No	Mitral Valve	Yes No	Tonsillitis	Yes No	For Women Only	
Bloody, persistent cough	Yes No	Nervous Problems	Yes No	Tumors	Yes No	Pregnant	Yes No
Diabetes	Yes No	Pacemaker	Yes No	Ulcer	Yes No	If yes, Due Date:	
Emphysema	Yes No	Unexplained Weight Loss	Yes No	Venereal Disease	Yes No	Nursing	Yes No
Artificial Joint	Yes No	Wear Contact lenses	Yes No	Taking Coumadin/Warfarin	Yes No	Taking Birth Control Pills	Yes No

Medical History Reviewed and discussed with patient. Provider Signature: _____ Date:_____

Authorization

I certify that the personal, medical and insurance information I have given on this registration form to be correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it's my responsibility to inform this office of any changes to my personal, insurance and medical status.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate by this office.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependents to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance company to submit payment directly to the dentist or dental practice.

I authorize the dentist and office staff to discuss my treatment, account history and/or payment arrangements with my spouse or domestic partner and parent if minor or under parents insurance policy unless I specifically advise them not to.

I understand and agree to give this office a minimum of 24 hours notice should I need to cancel an appointment, 48 hours notice for Saturday appointments. If notice is not given and/or I am more than 15 minutes late to an appointment, I understand that a missed appointment fee of $50.00 may be charged to my account.

I understand that I am financially responsible for any outstanding balance for services provided regardless of insurance status. Account Balances which are not paid within 30 days of statement will be subject to a 1% interest charge per month.

Patient, Parent or Guardian Signature: _____ Date: _____