ADULT PATIENT REGISTRATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of birth: _____

Preferred Name: _____ Please Indicate: Single / Married / Divorced + Male / Female

Address/Street: _____City:_____ State: _____ Zip:_____

Primary Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Email: _____ Can we text/email you regarding appointments? Yes No

Social Security Number: _____ (please provide, often required to bill your insurance)

DENTAL INSURANCE 1ST COVERAGE

Policy Holder Name: _____ Date of birth: _____
Relationship to Patient: _____ Employer Name: _____
Name of insurance company: _____
Address: _____City:_____ State: _____ Zip: _____
Phone number: _____
Member ID # _____ Group # _____

DENTAL INSURANCE 2nd COVERAGE

Policy Holder Name: _____ Date of birth: _____
Relationship to Patient: _____ Employer Name: _____
Name of insurance company: _____
Address: _____City:_____ State: _____ Zip: _____
Phone number: _____
Member ID # _____ Group # _____

I acknowledge that I have received a notice of privacy practices from Tanty Family Dental.
I authorize the release of information to the following people:

Name:_____ Relationship:_____ Phone number: _____

Name:_____ Relationship:_____ Phone number: _____

Name:_____ Relationship:_____ Phone number: _____

I give my consent to the release of information to the above mentioned persons and certify that the above information is complete and accurate.

PATIENT/GUARDIAN'S SIGNATURE: _____DATE: _____

PATIENT REGISTRATION

Who can we thank for referring you to our practice? _____

Emergency Contact

Name:_____ Phone number: _____

Relationship: _____

CONSENT FOR TREATMENT AND FINANCIAL ARRANGEMENTS:

I the undersigned, hereby authorize Tanty Family Dental to take radiographs, study models, photographs, records or any other diagnostic aids they deem appropriate to make a thorough diagnosis of my dental needs. I also authorize Tanty Family Dental to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent Tanty Family Dental to employ any such assistance as they deem appropriate under the law. I further authorize the release of diagnosis, radiographs, patient records, treatments or examinations render: to my insurance company, consulting professionals and others I approve.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. Reservations require a great deal of setup and preparation tailored to you and your treatment. **Last minute cancellations and missed reservations will be subject to a charged fee of $50.00. To avoid this charge, please contact our office within 48 hours of your reservation to make changes to your appointment(s).** We do understand that, on occasion last minute things do occur. If we both take our commitment to each other seriously, these issues are often avoidable.

I certify that the information given is correct and current. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independently of insurance reimbursement. Certain reservations may require payment in full unless approved arrangements have been made. I certify that I have also received a copy of the privacy policy.

PAYMENT DISCOUNTS

Payment is required the day of service and for our uninsured patients we offer a 10% discount for cash or check and 5% discount for all credit card transactions. **We accept** visa, master card, American express, discover and care credit.

WE ARE ALWAYS ACCEPTING NEW PATIENTS!

The highest form of a compliment is referring a new patient to us! Refer a new patient to our practice and receive $25 towards your dental treatment! This is an unlimited offer and does not expire!
Ask us today for a referral card and send your friends our way.

I certify that the above information is complete and accurate.

PATIENT/GUARDIAN'S SIGNATURE: _____DATE: _____

TANTY FAMILY DENTAL

DENTAL HEALTH HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

Reason for seeking our care today? Any specific concerns you'd like addressed?

_____

How would you like to hear your dental health information? Bottom Line Brief Detail Lots of Detail

If you could change something about the look/feel of your smile, what would it be?

◯ Replace missing teeth ◯ Whiter teeth ◯ Straighter teeth
◯ Replace mismatched crowns ◯ Repair chipped teeth
◯ I don't want to be embarrassed to smile in front of people

How often do you brush and floss? (please circle)

BRUSH 1 - 2 - 3+ PER: Day / Week / Month / Never
FLOSS 1 - 2 - 3+ PER: Day / Week / Month / Never

Date of last dental visit? _____ Date of last dental x-rays? _____

Previous Dentist (name, location, phone number)

_____ Phone Number: _____

_____

Please check the following items you have:

◯ Fixed Bridge ◯ Partial Denture ◯ Dentures ◯ Dental Implants ◯ Gum Surgery ◯ Jaw Surgery
◯ Orthodontics (braces) ◯ Root Canal ◯ Same Day Crown (Cerec) ◯ C-PAP Machine/Sleep Appliance
◯ Veneers

Please answer yes or no to the following:

Sensitivity to hot, cold, or sweets..... ◯ Yes ◯ No
Sore or bleeding gums ..... ◯ Yes ◯ No
Periodontal disease..... ◯ Yes ◯ No
Missing teeth ..... ◯ Yes ◯ No
Toothaches..... ◯ Yes ◯ No
Loose teeth..... ◯ Yes ◯ No
Offensive/Bad breath..... ◯ Yes ◯ No

Clicking/popping of jaw..... ◯ Yes ◯ No
Snoring (you've been told you snore)..... ◯ Yes ◯ No
Cold sores/oral lesions..... ◯ Yes ◯ No
Swollen glands..... ◯ Yes ◯ No
Growth(s) lesions in the mouth..... ◯ Yes ◯ No
Difficulty opening/chewing ..... ◯ Yes ◯ No

What matters most to you in your overall dental health: _____

How do you feel about your dental treatment? ◯ Relaxed ◯ Anxious ◯ Major Phobia

Any Additional Comments:

_____

I certify that the above information is complete and accurate.

PATIENT/GUARDIAN'S SIGNATURE: _____ DATE: _____

TANTY FAMILY DENTAL

MEDICAL HISTORY

Dental professionals primarily treat the area in and around your mouth. The mouth is part of your entire body and health problems that you may have and/or medication you may be taking could have an interrelationship with the dental care you will receive. Please answer the following questions. Thank you.

PATIENT NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

Who is your medical doctor or clinic?		
Have you ever been hospitalized or had a major operation?	Y N	Please Explain:
Have you ever had a serious head or neck injury?	Y N	
Do you use prescription pain medications or recreational drugs?	Y N	
Are you on a special diet?	Y N	
Do you have any type of disability?	Y N	
Have you been told to pre-medicate prior to dental visits?	Y N	
Are you taking any blood thinners such as aspirin regularly?	Y N	
Are you on or have you taken osteoporosis medications?	Y N	
Do you use chewing, smoking tobacco or e-cigarettes?	Y N	
WOMEN: Are you pregnant? How many months?	Y N	
Nursing?	Y N	

Please Provide a Complete List of All Medications (additional room on reverse)

_____ _____

_____ _____

Are you allergic to any of the following? (Please Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other Allergies:_____

DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE YES OR NO TO EACH QUESTION)

AIDS/HIV Positive	Y N	Convulsions	Y N	Heart Pace Maker	Y N	Radiation Treatment	Y N
Anaphylaxis	Y N	Diabetes Type I Type II	Y N	Heart Trouble/Disease	Y N	Recent Weight Loss	Y N
Anemia/Sickle Cell Disease	Y N	Drug or Alcohol Addiction	Y N	Hemophilia	Y N	Behavioral Health Issues	Y N
Angina	Y N	Easily Winded	Y N	Hepatitis A B C (please circle)	Y N	Renal Dialysis	Y N
Arthritis/Gout	Y N	Emphysema or COPD	Y N	Herpes (Oral)	Y N	Rheumatic Fever	Y N
Artificial Heart Valve	Y N	Epilepsy or Seizures	Y N	High Blood Pressure	Y N	Rheumatism	Y N
Artificial Joint (s)	Y N	Excessive Bleeding	Y N	Hives or Rash	Y N	Scarlet Fever	Y N
Asthma	Y N	Excessive Thirst	Y N	Hypoglycemia	Y N	Shingles	Y N
Blood Disorder	Y N	Fainting Spells/Dizziness	Y N	Irregular Heartbeat	Y N	Sinus Trouble	Y N
Blood Transfusion	Y N	Frequent Cough	Y N	Kidney Problems	Y N	Stomach/ Intestinal Disease	Y N
Breathing Problem	Y N	Frequent Diarrhea	Y N	Leukemia	Y N	Stroke	Y N
Bruise Easily	Y N	Frequent Headaches	Y N	Liver Disease / Yellow Jaundice	Y N	Swelling of Limbs	Y N
Cancer _____	Y N	Genital Herpes or other STDs	Y N	Low Blood Pressure	Y N	Tonsillitis	Y N
Chemotherapy	Y N	Glaucoma	Y N	Lung Disease	Y N	Tuberculosis	Y N
Chest Pain	Y N	Hay Fever / Seasonal allergies	Y N	Pain in Jaw Joints	Y N	Tumors or Growths	Y N
Cold Sores/Blisters	Y N	Heart Attack/Failure	Y N	Parathyroid/Thyroid Disease	Y N	Ulcers	Y N
Congenital Heart Disorder	Y N	Heart Murmur	Y N	Psychiatric Care	Y N	Neurological disorder	Y N
				Pregnant	Y N		

Preferred pharmacy _____ Phone number (_____) ____-_____

Have you ever had any serious illness not listed above? ____Y ____ N If yes, please explain:

_____

I certify that the above information is complete and accurate.

PATIENT/GUARDIAN'S SIGNATURE: _____DATE: _____