PATIENT REGISTRATION

NICHOLAS DENTAL CARE

Date: _____

LAST NAME_____ **FIRST NAME**_____ **MIDDLE NAME** _____

PREFERRED NAME: _____

Address: _____

City: _____ **State / Zip:** _____

E-Mail: _____

Cell: _____ **Home:** _____

Work: _____ **Ext / Other** _____

Where do you prefer to receive calls? ☐ **Cell** ☐ **Home** ☐ **Work**

Sex: ☐ **Male** ☐ **Female** **Age:** _____

Birth Date: _____

Soc. Sec. #: _____-_____-_____

Drivers Lic.: _____

Referred By

For Office Use Only ☐ **Nicholas Coverage** ☐ **Care Credit** **Account #:**

RESPONSIBLE PARTY (if someone other than the patient)

LAST NAME **FIRST NAME** **MIDDLE NAME**

Address: _____

City: _____ **State / Zip:** _____

E-Mail: _____

Cell: _____ **Home:** _____

Work: _____ **Ext:** _____

Where do you prefer to receive calls? ☐ **Cell** ☐ **Home** ☐ **Work**

Relationship to Patient: _____

Sex: ☐ **Male** ☐ **Female** **Age:** _____

Birth Date: _____

Soc. Sec. #: _____-_____-_____

Drivers Lic.: _____

INSURANCE INFORMATION

Primary

Name of Policy Holder: _____

Soc. Sec. #: _____-_____-_____ **D.O.B.** _____

Employer: _____

Insurance Co.: _____

Group #:_____ **ID #:** _____

Ins. Co. Address: _____

City: _____ **State / Zip:** _____

Phone: _____

Secondary

Name of Policy Holder: _____

Soc. Sec. #: _____-_____-_____ **D.O.B.** _____

Employer: _____

Insurance Co.: _____

Group #:_____ **ID #:** _____

Ins. Co. Address: _____

City: _____ **State / Zip:** _____

Phone: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Nicholas Dental Care Notice of Privacy Practices.

Patient, Parent or Guardian Name: _____ Signature: _____ Date: _____

MEDICAL HISTORY

NICHOLAS DENTAL CARE

Date: _____

LAST NAME_____ FIRST NAME_____ MIDDLE NAME _____

PREFERRED NAME: _____ Sex: ☐ Male ☐ Female Birth Date: _____ Age: _____

- Are you under medical treatment now? □ Yes □ No If yes _____
- Are you taking any medications? □ Yes □ No If yes _____

_____

- Have you been hospitalized for any major illness or surgery? □ Yes □ No If yes _____

_____

- Have you had any serious head or neck injury? □ Yes □ No If yes _____
- Have you been diagnosed with Osteoporosis? □ Yes □ No If yes _____
- Are you taking any medication for Osteoporosis? □ Yes □ No If yes _____
- Do you use controlled substances? □ Yes □ No If yes _____
- Do you use tobacco? □ Yes □ No
- Do you use alcohol? □ Yes □ No

Women Only: Please check all that applies

Are you… ☐ Taking oral contraceptives?

☐ Pregnant? ☐ Trying to get pregnant? ☐ Nursing?

Office Use Only ☐ N2O

Pre-Med with _____

_____

_____

_____

_____

_____

_____

Signature of Dentist Date

Are you allergic to any of the following? ☐ Latex ☐ Aspirin ☐ Penicillin

☐ Codeine ☐ Sulfa Drugs ☐ Iodine ☐ Metal ☐ Local Anesthetics

☐ Other_____

Primary Care Physician Name/ Phone

_____

AIDS/ HIV Positive	□ Yes □ No	Epilepsy or Seizures	□ Yes □ No	Liver Disease	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	Fainting Spells/ Dizziness	□ Yes □ No	Lung Disease	□ Yes □ No
Anaphylaxis	□ Yes □ No	Frequent Cough	□ Yes □ No	Pain in Jaw Joints	□ Yes □ No
Anemia	□ Yes □ No	Frequent Headaches	□ Yes □ No	Psychiatric Care	□ Yes □ No
Angina	□ Yes □ No	Genital Herpes	□ Yes □ No	Radiation Treatment	□ Yes □ No
Arthritis/ Gout	□ Yes □ No	Glaucoma	□ Yes □ No	Recent Weight Loss	□ Yes □ No
Artificial heart Valve	□ Yes □ No	Heart Attack/ Failure	□ Yes □ No	Renal Dialysis	□ Yes □ No
Artificial Joint / Other Part	□ Yes □ No	Heart Murmur	□ Yes □ No	Rheumatism	□ Yes □ No
Asthma	□ Yes □ No	Heart Pacemaker	□ Yes □ No	Shingles	□ Yes □ No
Bruise Easily	□ Yes □ No	Heart Trouble/ Disease	□ Yes □ No	Sickle Cell Disease	□ Yes □ No
Cancer	□ Yes □ No	Hemophilia	□ Yes □ No	Sinus Trouble	□ Yes □ No
Chemotherapy	□ Yes □ No	Hepatitis A	□ Yes □ No	Stomach/ Intestinal Disease	□ Yes □ No
Chest Pains	□ Yes □ No	Hepatitis B or C	□ Yes □ No	Stroke	□ Yes □ No
Cold Sores/ Fever Blisters	□ Yes □ No	Herpes	□ Yes □ No	Thyroid Disease	□ Yes □ No
Yellow Jaundice	□ Yes □ No	High Blood Pressure	□ Yes □ No	Tuberculosis	□ Yes □ No
Depression	□ Yes □ No	High Cholesterol	□ Yes □ No	Tumors or Growths	□ Yes □ No
Diabetes	□ Yes □ No	Hives or Rash	□ Yes □ No	Ulcers	□ Yes □ No
Drug Addiction	□ Yes □ No	Kidney Problem	□ Yes □ No	Venereal Disease / Which	□ Yes □ No
Easily Winded	□ Yes □ No	Leukemia	□ Yes □ No		
Emphysema	□ Yes □ No	Lyme Disease	□ Yes □ No	_____	

- Have you ever had any other serious illness not listed? □ Yes □ No If yes _____

Continued on back →

- What problem has brought you in to our office today? ____

- Do you clinch or grind your teeth that you are aware of? □ Yes □ No
- Do you have any cold sensitivity with any of your teeth? □ Yes □ No ________________

- Do you have sleep apnea □ Yes □ No
- Do you wear any dental/ other appliances, Night Guard, Retainer, Denture, etc.? □ Yes □ No ____________________

- Is there anything you don't like about your smile? ____

The best to 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.

Patient, Parent or Guardian Name: ______________________________ **Signature:** ____________________ **Date:** ____________

Date	Tooth	Service

Authorization & Release

I authorize Nicholas Dental Care to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and /or other health practitioners.

I authorize and request my insurance company to pay directly to the dental office insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient, Parent or Guardian Name: _____ **Signature:** _____ **Date:** _____

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 2.5% on the balance owed will be assessed each month.

I realize that failure to keep this account current may result in Nicholas Dental Care being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services.

In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Patient, Parent or Guardian Name: _____ **Signature:** _____ **Date:** _____

Our mission is to serve our patients by providing exceptional dental care in a comfortable friendly environment.