Smith Dental Hillsboro, 620 SE Oak Street, Suite D, Hillsboro, OR 97123 Phone: (503) 336-9458

PATIENT REGISTRATION & HEALTH HISTORY FORM

Date: ______________________

PATIENT INFORMATION

First Name: ______________________ M: __________

Last Name: ______________________

Preferred Name: ______________________

Address: ______________________

City: __________ State: __________ Zip Code: __________

Date of Birth: ______________________

Gender: ______________ Is the patient a minor? Yes ☐

Relationship Status: Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed ☐

Is the patient a student? Full Time ☐ Part Time ☐

Employer: ______________________

Phone: ______________________

Occupation: ______________________

Employer Address: ______________________

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Spouse's Name: ______________________

Date of Birth: ______________________

How did you hear about us?: ______________________

DENTAL INSURANCE

Who is responsible for this account? ______________________

Relationship to patient: ______________________

Insurance Co: ______________________

Group #: ______________________

Is patient covered by additional insurance? ______________________

Subscriber's Name: ______________________

Date of Birth: ______________________

Relationship to patient: ______________________

Insurance Co: ______________________

Group #: ______________________

ASSIGNMENT AND RELEASE. I certify that I, and/or my dependents have insurance coverage with ______________________ and assign directly to Smith Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above name dental practice may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

______________ ______________________
Date Relationship to Patient

CONTACT INFORMATION *REQUIRED INFORMATION*

*Cell Phone (_____)______________ Is it okay to send text messages for appointment confirmations and reminders? Yes ☐ No ☐

*Email Address: ______________________ This is used for appointment reminders/confirmations. This is never used for spam or given out to anyone else.

Home Phone (_____) ______________ Work Phone (_____) ______________ Best time and place to reach you: ______________

Emergency Contact: Name ______________ Relationship ______________ Phone (_____) ______________

DENTAL HISTORY

Reason for today's visit: ______________________

____

Date of last dental visit: ______________________

Date of last dental X-rays: ______________________

	Yes	No
Do you have bleeding gums?	☐	☐
Do you use any form of tobacco?	☐	☐
Do you have dry mouth?	☐	☐
Does food collect between your teeth?	☐	☐
Do you grind your teeth?	☐	☐
Any loose teeth or fillings?	☐	☐
Do you have any jaw pain?	☐	☐

SMILE EVALUATION	Yes	No
Would you like your teeth to be straighter?	☐	☐
Would you like your teeth to be whiter?	☐	☐
Have you noticed any wear or chipping of your teeth?	☐	☐

If there is anything you could change about your teeth, what would it be?

____

SLEEP HEALTH	Yes	No
Do you snore?	☐	☐
Do you wakeup not feeling refreshed?	☐	☐
Do you wakeup in the morning with headaches?	☐	☐
Is it hard to stay awake during the day?	☐	☐

HEALTH HISTORY

Yes	No	
☐	☐	AIDS/HIV
☐	☐	Anemia
☐	☐	Anxiety
☐	☐	Arthritis, Rheumatism
☐	☐	Asthma
☐	☐	Back Problems
☐	☐	Blood Disease
☐	☐	Cancer
☐	☐	Chemical Dependency
☐	☐	Chemotherapy
☐	☐	Circulatory Problems
☐	☐	Cortisone Treatments
☐	☐	Diabetes
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting or dizziness
☐	☐	Glaucoma
☐	☐	Headaches
☐	☐	Hepatitis Type ______

Yes	No	
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	Jaundice
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Nervous System Problems
☐	☐	Psychiatric Care
☐	☐	Radiation Treatment
☐	☐	Respiratory Disease
☐	☐	Shortness of Breath
☐	☐	Sinus Trouble
☐	☐	Swollen Neck Glands
☐	☐	Thyroid Problems
☐	☐	Tonsillitis
☐	☐	Tuberculosis
☐	☐	Tumor or growths on head
☐	☐	Ulcer

Yes	No	
☐	☐	Artificial Heart Valves
☐	☐	Artificial Joints
☐	☐	Abnormal Bleeding After Surgery
☐	☐	Congenital Heart Lesions
☐	☐	Heart Murmur
☐	☐	Mitral Valve Prolapse
☐	☐	Pacemaker
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Stroke
☐	☐	Premedication needed for dental visits?
☐	☐	Are You Pregnant?

Other Heart Problems: ______________________________

____

____

Other Medical Conditions: ______________________________

____

____

MEDICATIONS

Please list any medications that you are currently taking:

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____

____

____

____

Physician Name: ______________________________

Physician Location: ______________________________

Physician Phone: ______________________________

ALLERGIES

	Yes	No
Penicillin or other antibiotics	☐	☐
Aspirin	☐	☐
Codeine or other narcotics	☐	☐
Lodine	☐	☐
Latex	☐	☐
Local Anesthetic	☐	☐
Sulfa Drugs	☐	☐
Reaction to metals	☐	☐

Other/Details: ______________________________

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The undersigned hereby authorizes the doctors and staff at Smith Dental to perform dental exams, take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors at Smith Dental to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize the use of anesthetics and understand that use of anesthetics embodies a certain risk.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Sign here: ______________________________ Date: ______________________________

Doctor: ______________________________ Date: ______________________________