CAPITAL CITY DENTISTRY OF ATLANTA

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Email address:	Social security:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone: ( )	Cell phone: ( )

P.O. Box:	City:	State:	ZIP code:

Occupation:	Employer:	Employer phone: ( )

How did you hear about us? (please check one box): If a loved one, who may we thank?

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone : ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Name & Address of the insurance Company: Phone:

Subscriber's name:	Subscriber's SSN:	Birth date: / /	Group #:	ID #:	

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ( )	Work phone: ( )

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

Patient/Guardian signature *Date*

DENTAL HISTORY

Question	Yes	No
Do your gums bleed when you brush or floss?	☐ Yes	☐ No
Are your teeth sensitive to hot, cold, sweets or pressure?	☐ Yes	☐ No
Does food or floss catch between your teeth?	☐ Yes	☐ No
Is your mouth dry?	☐ Yes	☐ No
Have you ever had periodontal (gum) treatments?		
Have you ever had orthodontic (braces) treatment?	☐ Yes	☐ No
Have you ever had problems associated with previous dental treatment? If yes, please explain.	☐ Yes	☐ No
Is your home water supply fluoridated?	☐ Yes	☐ No
Do you drink bottled or filtered water?	☐ Yes	☐ No
Are you currently experiencing dental pain or discomfort?	☐ Yes	☐ No
Do you have ear aches or neck pain?	☐ Yes	☐ No
Do you have any popping, clicking or discomfort in the jaw?	☐ Yes	☐ No
Do you brux or grind your teeth?	☐ Yes	☐ No
Do you have sores or ulcers in your mouth?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
Do you participate in active recreational activities?	☐ Yes	☐ No
Had you ever had a serious injury to your head or mouth?	☐ Yes	☐ No

What is the reason for your visit today?	
How do you feel about your smile?	
Date of your last dental exam:	Date of last dental x-rays:

MEDICAL HISTORY

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS		
Name of the Drug	Strength	Frequency Taken

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐ Yes	☐ No
Date of replacement: Any complications?		
Do you take or are you scheduled to take alendronate (Fosamax©) or risedronate (Actonel©) for osteoporosis or Paget's Disease?	☐ Yes	☐ No
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia© or Zometa©) for bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, multiple myeloma or metastatic cancer? Date treatment began:	☐ Yes	☐ No
Do you use controlled substances (drugs)	☐ Yes	☐ No
Do you use tobacco (smoking, snuff, chew, bidis)	☐ Yes	☐ No
If so, how interested are you in stopping? Circle one: VERY SOMEWHAT NOT INTERESTED		

WOMEN ONLY		
Are you pregnant?	☐ Yes	☐ No
Number of weeks?		
Are you taking birth control or hormonal replacement?	☐ Yes	☐ No
Nursing?	☐ Yes	☐ No

ALLERGIES: Please check if you have, or have had, any abnormal symptoms to the following

☐ Local Anesthetics	☐ Metals	Other, please explain:
☐ Aspirin	☐ Latex	
☐ Penicillin or other antibiotics	☐ Iodine	
☐ Barbiturates, sedatives or sleeping pills	☐ Hay fever – seasonal	
☐ Sulfa Drugs	☐ Animals	
☐ Codeine or other narcotics	☐ Food	

Please check if you have or have had any of the following:

☐ Artificial (prosthetic) heart valve	☐ Mitral valve prolapse	☐ Sinus trouble
☐ Previous ineffective endocarditis	☐ Pacemaker	☐ Tuberculosis
☐ Damaged valves in transplanted heart	☐ Rheumatic fever	☐ Cancer/Chemotherapy/Radiation
☐ Congenital heart disease (CHD)	☐ Rheumatic heart disease	☐ Chest pain upon exertion
☐ Unrepaired, cyanotic CHD	☐ Abnormal bleeding	☐ Chronic pain
☐ Repaired (completely) within last 6 months	☐ Anemia	☐ Diabetes I or II
☐ Repaired CHD with residual defects	☐ Blood transfusion	☐ Eating Disorder
☐ Cardiovascular disease	If yes, date:	☐ Malnutrition
☐ Angina	☐ Hemophilia	☐ Gastrointestinal Disease
☐ Arteriosclerosis	☐ AIDS or HIV	☐ GE Reflux/persistent heartburn
☐ Congestive heart failure	☐ Arthritis	☐ Ulcers
☐ Damaged heart valves	☐ Autoimmune disease	☐ Thyroid problems
☐ Heart attack	☐ Rheumatoid arthritis	☐ Stroke
☐ Heart murmur	☐ Systemic lupus erythematosus	☐ Glaucoma
☐ Low blood pressure	☐ Asthma	☐ Hepatitis

☐	High blood pressure	☐	Bronchitis	☐	Epilepsy
☐	Other congenital heart defects	☐	Emphysema	☐	Fainting spells or seizures
☐	Neurological Disorders	☐	Recurrent Infections	☐	Kidney Problems
	Specify:		Type of Infection:	☐	Excessive urination
☐	Night sweats	☐	Osteoporosis	☐	Persistent swollen glands
☐	Severe headaches/migraines	☐	Severe or rapid weight loss	☐	Sexually transmitted disease
☐		☐		☐	

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐ Yes	☐ No
Name of physician or dentist making the recommendation: Phone:		
Do you have any disease, condition or problem not listed above that you think I should know about? Please explain:	☐ Yes	☐ No

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Accounting Information:
I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient. I also agree to assume full financial responsibility for all treatment rendered.

Signature of Patient/Legal Guardian: Date: