EXCEPTIONAL DENTISTRY – CRAIG RATNER DMD

PATIENT REGISTRATION

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

Preferred Name: _____

Address: _____ Home Phone: (___)_____

_____ Work Phone: (____)_____

City/State/Zip : _____ Cell Phone: (____)_____

○ I would like to receive e-mail notifications. Email: _____

Sex: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Soc. Sec. No.: _____

Responsible Party (if someone other than you)

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

Address: _____ Home Phone: (___)_____

_____ Work Phone: (____)_____

City/State/Zip: _____ Cell Phone: (____)_____

Birth Date: _____ Soc. Sec. No.: _____

Primary Dental Insurance

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured's Soc. Sec. No. or Insurance ID: _____ Insured's Birth Date: _____

Insured's Employer: _____ Insurance Company:_____

Group Number: _____ Address:_____

_____

Secondary Dental Insurance

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured's Soc. Sec. No. or Insurance ID: _____ Insured's Birth Date: _____

Insured's Employer: _____ Insurance Company:_____

Group Number: _____ Address:_____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this document

I, _____, have received a copy of this office's Notice of
(Please Print Full Name)
Privacy Protection.

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained.

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

  _____
  _____

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MEDICAL HISTORY

What medications are you currently taking? (Please include all vitamins and homeopathic supplements)

_____

_____

	Yes	No
Are you currently under the care of a physician?	○	○

If yes, please give the name of the physician and explain current treatment:

_____

_____

Women: Are you…
Pregnant/Nursing? ○Yes ○No Taking Oral Contraceptives? ○Yes ○No

Are you allergic to any of the following? ○Latex ○ Penicillin ○ Codeine ○ Acrylic ○ Aspirin
○ Metal ○Acrylic ○ Local Anesthetics ○ Other, please explain:_____

Check if you have or have had any of the following:

- ○ AIDS/HIV Positive
- ○ Alzheimer's Disease
- ○ Anemia
- ○ Angina
- ○ Arthritis/Gout
- ○ Artificial Heart Valve
- ○ Artificial Joint
- ○ Asthma
- ○ Breathing Problem
- ○ Bruise Easily
- ○ Cancer
- ○ Chemotherapy
- ○ Chest Pains
- ○ Cold Sores/Fever Blisters
- ○ Congenital Heart Disorder
- ○ Convulsions
- ○ Diabetes
- ○ Drug Addiction
- ○ Easily Winded
- ○ Emphysema
- ○ Epilepsy or Seizures
- ○ Excessive Bleeding
- ○ Fainting Spells/Dizziness
- ○ Genital Herpes
- ○ Glaucoma
- ○ Hay Fever
- ○ Heart Attack/Failure
- ○ Heart Murmur
- ○ Heart Pace Maker
- ○ Heart Trouble/Disease
- ○ Hemophilia
- ○ Hepatitis A
- ○ Hepatitis B or C
- ○ Herpes
- ○ High Blood Pressure
- ○ Hives or Rash
- ○ Hypoglycemia
- ○ Irregular Heartbeat
- ○ Kidney Problems
- ○ Leukemia
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Lung Disease
- ○ Mitral Valve Prolapse
- ○ Parathyroid Disease
- ○ Psychiatric Care
- ○ Radiation Treatments
- ○ Recent Weight Loss
- ○ Renal Dialysis
- ○ Rheumatic Fever
- ○ Rheumatism
- ○ Scarlet Fever
- ○ Shingles
- ○ Sinus Trouble
- ○ Stomach/Intestinal Disease
- ○ Stroke
- ○ Thyroid Disease
- ○ Tonsillitis
- ○ Tuberculosis
- ○ Tumors or Growths
- ○ Ulcers
- ○ Venereal Disease
- ○ Yellow Jaundice

If you have ever had a serious illness not listed above, please explain:_____

_____

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DENTAL HISTORY

	Yes	No
Do your gums bleed while brushing or flossing?..	○	○
Are your teeth sensitive to hot or cold liquids/foods?.....	○	○
Are your teeth sensitive to sweet and/or sour liquids/foods?.....	○	○
Do you feel pain in any of your teeth?.....	○	○
Do you have any sores or lumps in or near your mouth?.....	○	○
Do you snore or have obstructive sleep apnea?...	○	○
Do you use a CPAP machine for apnea?.....	○	○
Do you experience significant daytime drowsiness?.....	○	○
What neck size are your shirts?_____		
Have you ever had any cosmetic procedures to:		
Volumize or add definition to your lips.....	○	○
Increase or add definition to your cheekbones.....	○	○
Minimize wrinkles on your face/forehead.....	○	○
Decrease nasolabial/marionette lines.....	○	○
Have you ever had any cosmetic procedures such as:		
Botox®, Dysport®, Xeomin®.....	○	○
Juvederm®, Restylane®, Sculptra®.....	○	○
Radiesse®.....	○	○

	Yes	No
Do you have frequent headaches and/or migraines?.....	○	○
Do you clench or grind your teeth?.....	○	○
Have you ever had orthodontic treatment?.....	○	○
Have you had any head, neck, and/or jaw injuries?.....	○	○
Have you experienced any of the following problems in your jaw?		
Clicking and/or Popping.....	○	○
Pain (joint, ear, side of the face).....	○	○
Difficulty in opening or closing.....	○	○
Difficulty in chewing.....	○	○
Chronic sinus or ear congestion.....	○	○
Do you participate in any contact sports?	○	○
If yes, do you wear a mouth guard?.....	○	○
If yes, is it a performance enhancing mouth guard?.....	○	○
Do you like your smile?.....	○	○
If no, please describe what you would like to change		
_____		
_____		

To the best of 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/dental status. I understand and agree that I am responsible for payment for all treatment rendered on my behalf or my dependants at the time of service.

X _____.

Signature of Patient, Parent, or Guardian Date