Robert C Todd DMD
Patient Registration Form

Today's Date _____ Date of Birth _____

Patient's Name _____

Spouse's Name _____

If Child, Parent's Name _____

Name you prefer to be called _____

Residence Address:

Street _____

City _____ State _____ Zip _____

Business Address:

Street _____

City _____ State _____ Zip _____

Telephone:

Residence _____ Business _____

Best Time to Call _____

May we call you at work? YES/NO If yes, best time is _____

Cell Phone NO. _____

E-Mail Address _____

Who is responsible for payment of this account? _____

Method of Payment: Cash Check Credit Card

If you would like us to process your dental insurance for your reimbursement, Please complete the back of this form.

Other family members who have been treated at our office: _____

Whom may we thank for this referral? _____

Someone to notify in case of emergency: Name _____

Phone No. _____

Consent for dental treatment:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care and treatment provided, for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care and treatment to another dentist. I understand that I am responsible for all costs of dental treatment. I authorize use of my dental photographs for publication or educational purposes.

Patient Signature (or Guardian if under 18) _____

Robert C Todd DMD
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Dental Insurance Primary Coverage

Employee Name _____
Employee Date of Birth _____
Employee Social Security Number _____
Employer _____
Employer's Address _____
Employer's Phone No. _____
Name of Insurance Company _____
Insurance Co. Address _____
Policy Number _____
Group Name _____
Payor ID# _____

Dental Insurance Secondary Coverage

Employee Name _____
Employee Date of Birth _____
Employer _____
Employer's Address _____
Employer's Phone No. _____
Name of Insurance Company _____
Insurance Co. Address _____
Insurance Co. Phone Number _____
Policy Number _____
Group Name _____
Payor ID# _____

We will complete and file all insurance claims for your reimbursement. We will also file insurance claims for secondary coverage.

Insured Signature _____

Robert C. Todd, DMD
Patient Health History

Name: _____ Date:_____

The following health history is designed to help us provide you with the best dental care possible. Please assist us by answering all questions as accurately as possible.

Medical History

YES NO 1. Have there been any significant changes in your health in the past year?
If so, please explain_____

YES NO 2. Are you currently or have you taken any medication within the last six weeks?
If so, please list the medicine and it's dosage. _____
_____
_____

YES NO 3. Have you ever had an unusual or allergic reaction to any drug or medication (including dental anesthetic, penicillin, aspirin, codeine, or others)? If so, please explain_____
_____

YES NO 4. Do you bleed a long time when you are cut or after having a tooth extracted?

YES NO 5. Have you or any members of your immediate family ever had tuberculosis? If so, who? _____

YES NO 6. Have you or any members of your immediate family ever had hepatitis or liver disease? If so, who? _____

YES NO 7. Have you ever been treated for the HIV (Aids) virus?

YES NO 8. Have you ever been told that you cannot donate blood?
If so, why?_____

YES NO 9. Have you ever been told that you need to take penicillin or some other antibiotic prior to dental treatment? If so, why? _____
_____

YES NO 10. Do you have excessive urination or thirst?

YES NO 11. (Children) Are your immunizations current?

YES NO 12. (Women) Are you pregnant? If so, how many months _____

YES NO 13. Have you ever had any of the following: (check all that apply)

_____	High / Low Blood Pressure	_____	Radiation treatments
_____	Rheumatic Fever	_____	Diabetes (sugar)
_____	Arthritis	_____	Heart Trouble
_____	Stroke	_____	Emphysema
_____	Persistent Cough	_____	Glaucoma
_____	Venereal Disease	_____	Asthma
_____	Epilepsy		

14. Name of physician _____
Address _____
_____
Telephone number_____

Dental History

1. What is the reason for your visit? _____
   _____
2. When was your last dental visit?_____

YES NO 3. Do your gums bleed when you brush or floss your teeth?

YES NO 4. Are any of your teeth sensitive to temperature or sweets?
If so, which ones _____

YES NO 5. Do you have any difficulty chewing your food? If so, please explain
_____

YES NO 6. Have you noticed any loosening of your teeth? If so, which ones?
_____

YES NO 7. Do your jaws pop or lock when opening your mouth? If so, please explain
_____
_____

YES NO 8. Do you suffer from frequent headaches?

YES NO 9. Do you snore?

YES NO 10. Do you have a C-PAP machine? If so do you use it?_____

YES NO 11. Do you have any disease, condition or problem not listed above that I should know about? _____
_____

YES NO 12. Would you be interested in learning some new information that would give you or your family members fresher breath?

PATIENT SIGNATURE (or guardian if under 18)

_____

DATE: _____

If you haven't been to the office for one year or longer, please review the answers on your health history. List any changes below. Thank you for taking the time to complete this form.

DATE	CHANGES	SIGNATURE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____