Patient Name

Last First Initial

Soc. Sec # | | | - | | - | | | |

Birthdate | | / | | / | |

Month Day Year

David M. Nelson, DDS, PA
New Patient Registration

If Child, Parent's Name:_____
How do you wish to be addressed: _____
Check one:
☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Minor
Residence (Street address): _____
City/State/Zip: _____
Business Address:_____
Telephone: Res. Bus._____
Fax: Cell Phone # _____
email: _____
Patient/Parent Employed By:_____
Present Position: _____
How Long Held: _____
Spouse/Parent Name: _____
Spouse Employed By: _____
Present Position: _____
How Long Held: _____
Who is Responsible for this account: _____
Drivers License No.:_____
Method of Payment: ☐Insurance ☐Cash ☐Credit Card
Other Family Members in this Practice:_____
Whom may we thank for this referral: _____
Patient/parent Social Security No.: _____
Spouse/Parent Social Security No.:_____
Someone to notify in case of emergency not living with you: _____
Relationship: Phone #:_____
Address:_____

Consent

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

PATIENT Signature (Parent of Child) _____
Date:_____
DENTIST Signature _____

Dental Insurance: First Coverage

Employee Name_____ Date of Birth_____
Employer Name Yrs. _____
Name of Insurance Co. _____
Address _____
Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group_____

Dental Insurance: Second Coverage

Employee Name_____Date of Birth _____
Employer Name Yrs. _____
Name of Insurance Co. _____
Address _____
Telephone_____
Program or policy #_____
Social Security No._____
Union Local or Group_____

Financial Arrangements

We offer the following payment options:

- We are a fee for service office.
- We gladly accept insurance assignments for patients with dental insurance, but require payment for the deductible and non-covered fees to be paid at each visit.
- I understand that my insurance is an agreement between my insurance company and myself. I also understand that I am responsible for the balance of my dental account regardless of my insurance. I further understand that a late charge will be added to any overdue balance.
- I assign dental payments to be paid directly to Dr. Nelson from my insurance carrier.
- Payment in full by cash or check.
- Bank charge card -- Visa, Mastercard and Discover are accepted.
- Monthly payment plan: Financing is available through Care Credit (subject to credit approval).
- Major services: Appliances, crowns and bridges. Payments of 1/2 at the initial appointment and 1/2 upon completion. Partials and dentures must be paid for in full before they can be sent for processing.

REGISTRATION

Cut immediately ABOVE this line

Patient Name _____ **Soc. Sec. #** ___ - ___ - ____ **Birthdate** ___ / ___ / ____

Last First Initial Month Day Year

01. **PURPOSE** of initial visit _____
02. Are you aware of a **PROBLEM**? _____
03. **HOW LONG SINCE** your last dental visit? _____
04. **WHAT WAS DONE** at that time? _____
05. Previous dentist's name _____
    Address: _____ Phone: _____
06. When was the **LAST TIME** your teeth were **CLEANED**? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

07. Have you made regular visits? . . . . . Yes No
    How often? _____
08. Were **DENTAL X-RAYS** taken? . . . . . Yes No
09. Have you **LOST ANY TEETH** or have any **TEETH BEEN REMOVED**? . . . . . Yes No
    Why? _____
10. Have they been replaced? . . . . . Yes No
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
12. Are you **UNHAPPY** with the replacement? . . . . . Yes No
    If yes, explain _____
13. Would you like to know about **PERMANENT REPLACEMENTS**? . . . . . Yes No
14. Have you had any problems or complications with previous dental treatment? If yes, explain _____
15. Do you **CLENCH** or **GRIND** your teeth? . . . . . Yes No
16. Does your jaw **CLICK** or **POP**? . . . . . Yes No
17. Have you experienced any **PAIN** or **SORENESS** in the muscles of your face or around your ear? . . . . . Yes No
18. Do you have **FREQUENT HEADACHES, NECKACHES** or **SHOULDER ACHES**? Yes No
19. Does **FOOD** get **CAUGHT IN YOUR TEETH**? . . . . . Yes No
20. Are any of your teeth **SENSITIVE** to:
    ☐ Hot ☐ Cold ☐ Sweets ☐ Pressures
21. Do your gums **BLEED OR HURT**? . . . . . Yes No
    When? _____
22. How often do you brush your teeth? . . . . . Yes No
23. Do you use **DENTAL FLOSS**? ☐ Yes ☐ No How often? _____
24. Are any of your teeth **LOOSE, TIPPED, SHIFTED** or **CHIPPED**? _____
25. Are you unhappy with the **APPEARANCE** of your teeth? _____
26. **HOW DO YOU FEEL** about your teeth in general? _____
27. Do you feel your **BREATH IS OFFENSIVE** at times? _____
28. Have you ever had **GUM TREATMENT** or **SURGERY**? _____
    What? _____
    When? _____
    Where? _____
29. Have you had any **ORTHODONTIC** work? _____
30. Have you had any **UNPLEASANT** dental experiences or is there anything about dentistry that you **STRONGLY DISLIKE**? _____
31. Do you have any questions or concerns? _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

DENTAL HISTORY

Cut immediately ABOVE this line

Patient Name _____
Last First Initial

Soc. Sec. # ___ - ___ - ____

Birthdate ___ / ___ / ____
Month Day Year

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

01. Physician's name _____
Address: _____
02. Are you under a physician's care? . . . . . YES NO
Since when? _____ Why? _____
03. When was your last **COMPLETE** physical exam? _____
04. Are you taking any medication or substances? _____
(If yes, please list meds in comments section at left or on backside.)
05. Do you routinely take health-related substances? _____
07. Do you have any other allergies _____
08. Do you have any **PROBLEMS** with **PENICILLIN, ANTIBIOTICS, ANESTHETICS** or other meds? . . . . . YES NO
09. Are you **SENSITIVE** to any **METALS** or **LATEX**? . . . . . YES NO
10. Are you **PREGNANT** or suspect you may be? . . . . . YES NO
11. Do you use any **BIRTH CONTROL** medications? . . . . . YES NO
12. Have you ever been **TREATED** for or **TOLD** you might have **HEART DISEASE**? . . YES NO
13. Do you have a **PACEMAKER** or an **ARTIFICIAL HEART VALVE** implant? . . . . . YES NO
14. Have you ever had **RHEUMATIC FEVER**? . . . . . YES NO
15. Are you aware of any **HEART MURMURS**? . . . . . YES NO
16. Do you have **HIGH** or **LOW BLOOD PRESSURE**? . . . . . YES NO
17. Have you ever had a **SERIOUS ILLNESS** or **MAJOR SURGERY**? . . . . . YES NO
If so, explain: _____
18. Have you ever had **RADIATION TREATMENT, CHEMO TREATMENT** for tumor, growth or other condition? . . . . . YES NO
19. Do you have **INFLAMMATORY DISEASES** such as arthritis or rheumatism? . . . . . YES NO
20. Do you have any **ARTIFICIAL JOINTS/PROSTHESIS**? . . . . . YES NO
21. Do you have any **BLOOD DISORDERS**, such as anemia, leukemia, etc.? . . . . . YES NO
22. Have you ever **BLED EXCESSIVELY** after being cut or injured? . . . . . YES NO
23. Do you have any **STOMACH PROBLEMS**? . . . . . YES NO
24. Do you have any **KIDNEY PROBLEMS**? . . . . . YES NO
25. Do you have any **LIVER PROBELMS**? . . . . . YES NO
26. Are you **DIABETIC**? . . . . . YES NO
27. Do you have **ASTHMA**? . . . . . YES NO
28. Do you have **EPILEPSY** or **SEIZURE DISORDERS**? . . . . . YES NO
29. Do you have or have you had **VENEREAL DISEASE**? . . . . . YES NO
30. Have you tested **HIV POSITIVE**? . . . . . YES NO
31. Do you have **AIDS**? . . . . . YES NO
32. Have you had or do you test positive for **HEPATITIS**? . . . . . YES NO
33. Do you or have you had **T.B.**? . . . . . YES NO
34. Do you **SMOKE, CHEW, USE SNUFF** or any other **FORMS OF TOBACCO**? . . . . YES NO
35. Do you consume **ALCOHOLIC** beverages? . . . . . YES NO
36. Do you habitually use **CONTROLLED** substances? . . . . . YES NO
37. Have you had psychiatric treatment? . . . . . YES NO
38. Have you taken **FENFLURAMINE** or **FENFLURAMINE** combined w/ **PHENTERMINE** **(fen-phen)**, dexfenfluramine (**redux**) or other weight loss products? . . . . . YES NO
39. Do you have any disease, condition or problem not listed? . . . . . YES NO
If yes, please explain: _____
40. Is there anything else we should know about your health that we have not covered on this form? If yes, please explain: _____ YES NO
41. Would you like to speak with the Doctor privately about any problem? . . . . . YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

COMMENTS

Medical Alert

MEDICAL HISTORY