

Patient Registration

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Name _____ Name prefer to be called: _____
Address _____ City/State _____ Zip _____
Employer _____ Occupation _____ Lic.# _____
Home Phone _____ Business Phone _____ Soc. Sec # _____
Email Address _____ Cell Phone _____
Birthdate _____ Age _____ Sex _____ Marital Status (circle one): M S W D
In event of an emergency please contact _____ Phone _____
Who can we thank for telling you about our office? _____

Person Responsible for Payment of Account (or person with insurance)

Name _____ Relationship to patient _____
Address _____ City/State _____ Zip _____
Employer _____ Occupation _____
Employer address _____
Home Phone _____ Business Phone _____ Extension _____
Birthdate _____ Sex _____ Soc. Sec# _____

Dental Insurance Information

Primary Insurance company _____ Employer _____
Subscriber's Name _____ Soc. Sec. # _____
Group Number _____ I.D.# _____
Patient's relationship to subscriber: Self..... Spouse Child

I understand that insurance coverage is a contract between myself and the insurance company and that the doctor makes all treatment recommendations based upon the best interests of the patient and not the availability of insurance coverage. The doctor and staff make no guarantees whatsoever regarding insurance reimbursements; if my insurance company fails to pay Dr. Traub, I will be responsible for the full amount. I further understand that all fees will be paid in full by me at the time of treatment, unless I accept and sign this insurance assignment agreement. I understand that if there is a balance after insurance pays, I will be billed for and responsible for that amount. I understand that by signing below I agree to these terms and I authorize the release of any information necessary to process my insurance claim. I hereby authorize insurance payment to Dr. Traub. A copy of this signature is valid as the original.

Signature _____ Date _____

TMD History

| | | |
|--|-----|----|
| Have you ever had a problem with your TMJ (jaw joints)? | Yes | No |
| Have you ever had an injury to the jaw? | Yes | No |
| Do your jaw joints ever hurt or become tender when you chew, talk, or open wide? | Yes | No |
| Do you ever hear any clicks, pops, or grating sounds in your jaw joints? | Yes | No |
| Does your jaw ever get stuck, or locked or go "out"? | Yes | No |
| Do you ever have difficulty opening your jaw? | Yes | No |
| Do you ever have a problem with your joints when you eat or chew? | Yes | No |

(OVER)

Medical History

Are you in good health?..... Yes No
Has there been any change in your general health in the last year?..... Yes No
Are you under the care of a physician? Yes No
If so, what is the condition being treated? _____
Name of physician _____ Phone _____
Have you recently been seriously ill, had operations, or been hospitalized?..... Yes No
If so, what was the illness? _____
Are you taking any medications including non prescription medications? Yes No
If so, please list (include herbal and dietary supplements) _____

Circle any of the problems you may have:

| | | | |
|-------------------------|-----------------------|---------------------|-------------------|
| Damaged heart valve | Asthma/Hay fever | High blood pressure | Pacemaker |
| Heart murmur | Fainting or seizures | Chest pain | Allergy |
| Rheumatic heart disease | Diabetes | Kidney disease | Sinus trouble |
| Stroke | AIDS or HIV infection | Epilepsy | Abnormal bleeding |
| Heart attack | Thyroid disease | Cancer | Cochlear implant |
| Angina | Emphysema | Hepatitis | STD |
| Coronary artery disease | Arthritis | Heart defect | Joint replacement |

Do you have any diseases, conditions, or problems not listed above? Yes No
If so, explain _____
Have you ever been told to take any medications before dental appointments? Yes No
If so, explain _____
Are you allergic to any medications or latex products? Yes No
Circle if you are allergic to: novocaine, local anesthetic, penicillin, antibiotics,
barbiturates, sedatives, aspirin, codeine, narcotics or any other medications.
Women: Are you pregnant Yes No If so, what month _____

Dental History

Have you had any serious trouble associated with past dental treatment?..... Yes No
If so, explain _____
Have you ever required sedation or nitrous oxide for dental treatment?..... Yes No
Have you ever had a removable dental appliance made for you?..... Yes No
When was the appliance last made? _____
About when was your last dental treatment? _____ Last cleaning? _____
Have you had a full set of x-rays in the last 3 years?..... Yes No
Are you having any dental problems at this time? Yes No
If so, please explain _____
What is the purpose of your visit with us today? _____

Are you pleased with the appearance of your teeth? Yes No
If no, please explain what bothers you _____

I certify that I have read and understand the above questions. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Parent _____ Date _____