REGISTRATION

ALL PATIENTS PLEASE COMPLETE

PLEASE CIRCLE TITLE
Mr. Mrs.
Dr. Miss _____ _____ _____ _____

Date: _____

LAST FIRST MI JR/SR. ETC.

_____ _____/_____/_____ __S__M__D__W__ __M__F__

SOCIAL SECURITY NO. DATE OF BIRTH MARITAL STATUS GENDER

Address: _____

STREET CITY STATE ZIP

Telephone: _____

HOME OFFICE CELLULAR PAGER

Email Address: _____ Employer: _____

Who is responsible for payment: _____ *PLEASE NOTE: Responsible party must live with patient*

In case of emergency contact: _____ _____ _____

NAME PHONE RELATIONSHIP

Whom may we thank for referring you to us? _____

Are other members of your family patients here? Y N Who? _____

IF YOU HAVE INSURANCE

INSURANCE INFORMATION

Policy Holder's Name _____

Social Security No. _____

Date of Birth: _____

Employer _____

Relationship of patient to policy holder:

Circle: Self Spouse Dependent Child

_____

NAME OF INSURANCE COMPANY

_____

ADDRESS OF COMPANY

_____

PHONE POLICY NO. GROUP NO.

Are you covered by Secondary Insurance? Y N

Policy Holder's Name _____

Social Security No. _____

Date of Birth: _____

Employer _____

Relationship of patient to policy holder:

Circle: Self Spouse Dependent Child

_____

NAME OF INSURANCE COMPANY

_____

ADDRESS OF COMPANY

_____

PHONE POLICY NO. GROUP NO.

IF PATIENT IS A MINOR OF DEPENDENT

PARENT OR GUARDIAN INFORMATION

Name _____

LAST FIRST MI

Address _____

STREET CITY

_____

STATE ZIP E-MAIL

Phone _____

HOME OFFICE CELLULAR

Parent Social Security No. _____

Date of Birth: _____

Is patient a full time student? Y N

Where is patient a student? _____

I authorize the doctor's use of my models, photos, x-rays and images for use in seminars, demonstrations and continuing education. All above answers are true and correct. If there are any changes to the above information, I will inform this office immediately. I authorize the release of any dental or medical information necessary to insure proper care and request that payment of benefits be made to Dr. Leigh Ledford. I understand that I am personally responsible for all fees and any charges that are incurred to collect those fees.

_____

SIGNATURE DATE

MEDICAL HISTORY

HILLCREST COSMETIC AND FAMILY DENTISTRY

ALL PATIENTS PLEASE COMPLETE

Name: _____ _____ _____ Date:_____

LAST FIRST MI

Names Of Your Doctors_____ _____ _____

PRIMARY CARE PHYSICIAN OTHER OTHER

Please circle YES or NO

Y N Are you presently under a doctors care? For what condition? _____

Y N Have you had any operations? If so, what?_____

Y N Have you ever tested positive for the HIV (aids) virus? If so, what is your present status?_____

Y N Are you in high risk group for HIV infection?

Y N Have you ever had a blood transfusion? If so, when?_____

Are you allergic to any of the following? List any other drug to which are allergic_____

Y N Penicillin Y N Novocaine Even if it is an over the counter medication: _____

Y N Sulfa Drugs Y N Aspirin _____

Y N Codeine Y N Advil _____

Have you ever received

Y N An Artificial Heart Valve Y N Joint Replacement

Y N Pacemaker Y N A Donor Organ

Have you ever had or do you currently have any of the following:

Y N Heart Ailment Y N Diabetes

Y N Mitral Valve Prolapse Y N Blood Disease or Disorder

Y N High Blood Pressure Y N Liver Disease or Disorder

Y N Low Blood Pressure Y N Respiratory Disease or Disorder

Y N Rheumatic Fever Y N Abnormal Bleeding

Y N Tumors or Growths Y N Sexually Transmitted Diseases

Y N Are You Pregnant Y N Take Birth Control Pills

If you answered YES to any of the above, please give details here:_____

_____

_____

Y N Reaction to Novocaine Describe:_____

Y N Asthma How often do you have an attack?_____ Y N Do you have an inhaler with you?

Y N Epilepsy How often do you have an episode?_____ Y N Do you know your trigger?_____

What medication do you take to control your Epilepsy? _____

Y N Do you use cocaine or other street drugs? *You are at risk of sudden death if I treat you without knowledge of this use*.

Please list all of your medications both prescription and over the counter:_____

_____

_____

Y N *Are you required to use any medication prior to dental appointments?* What?_____

Y N Is there anything else about your medical history that has not been covered?_____

_____

_____

_____

_____

DENTAL HISTORY

ALL PATIENTS PLEASE COMPLETE

Name:_____ _____ _____ Date:_____

LAST FIRST MI

When was your last complete dental examination?_____ Name of former dentist: _____

Please circle correct response

Y N Where there any diagnosed conditions that were not treated?_____

How often do you brush?_____ Do you floss? Y N If yes, how often?_____

Y N Do you use an electric toothbrush? If so, what brand?_____

Y N Do you use an oral irrigation device? If so, what brand? _____

Y N Have you ever had orthodontic treatment (braces)?_____

Y N Have you ever had a bad experience in a dental office? If so, please tell me about it._____

_____

Y N Are you having any areas of discomfort at this moment? If so, where?_____

_____

IF PATIENT IS LESS THAN 16 YRS.OLD YOU MAY STOP.
IF 16 YRS.OLD OR MORE PLEASE CONTINUE.

Y N Not sure Have you had your wisdom teeth removed?

Y N Have you ever had a dry socket after an extraction?

Y N Have you been told that you have periodontal disease?

Y N If so, was treated? If yes, surgically or non-surgically?

Y N Do your gums bleed easily or are they swollen, red or tender?

Y N Are your gums pulling away from your teeth?

Y N Do you feel you have bad breath?

Y N Do you presently smoke? Y N Did you ever smoke?

Y N Do you drink alcoholic beverages? How many per day?____

Y N Do you presently use smokeless tobacco? Y N Did you ever?

Y N Do you have frequent headaches?

Y N Do you have difficulty opening your mouth widely?

Y N Do you hear noises from your jaw joints?

If so, describe:_____

Y N Does your bite feel uncomfortable?

Y N Have you ever been told that you have temporomandibular joint disorder (TMJ)?

Y N If so, did you have treatment?

Y N Do you wear bite splint?

Y N Have you ever had your bite adjusted (Equilibrated)?

Y N Has anyone ever told you that you snore?

Y N Have you been diagnosed with sleep apnea?

PLEASE CONTINUE

If you had a magic wand, what would you change about your teeth and smile? Use back page if needed_____

_____

_____

Y N Are your teeth as white as you would like?

Y N Do you have discolored or dark fillings that you wish you could change? _____

On a scale with 1 being "not important at all" and 10 being "extremely important, how important to you are your teeth and smile? _____

What preventing you from obtaining top quality, esthetic dental care?

Please circle all that apply: Fear Cost Time Inconvenience Completing priorities Lack of trust

Please explain:_____

Y N Is there anything else that I should know to help in your diagnosis? Use back if needed

_____

_____

_____