Gorham Family Dentistry, P.A.

Patient Registration

Name: Date of Birth: SS#:

Mailing Address:

City: State: Zip: Home Phone: ( ) Cell Phone: ( )

Occupation: Employer: Work Phone: ( )

Email Address: Preferred Method of Contact:

Emergency Contact: Relationship: Phone #: ( )

Physician: Phone #: ( ) Date of Last Visit:

Previous Dentist: Date of Last Visit:

If you are completing this form for another person, what is your relationship to that person?

Name: Relationship:

Do you have any of the following diseases or problems:	**Yes**	**No**
Active Tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐
Been exposed to anyone with tuberculosis	☐	☐

If you answered yes to any of the 4 questions above, Please stop and return this form to the receptionist. If no please continue….

	Yes	**No**
Are you presently under the care of a physician?	☐	☐
Are you in good health?	☐	☐
Has there been a change in your health within the last year?	☐	☐

Do you use tobacco in any form? If Yes, how much? How long?

Do you use alcoholic beverages (more than 2 drinks daily?)

WOMEN: Are you pregnant? If Yes, how far along?

What is the reason for your visit today?

Whom may we thank for referring you?

Dental Insurance

Subscriber's Name: Date of Birth: ID #:

Employer: Group #:

Insurance Company: Phone #: ( )

Address: City: State: Zip:

If you have a Secondary Insurance please list:

Subscriber's Name: Date of Birth: ID #:

Employer: Group #:

Insurance Company: Phone #: ( )

Address: City: State: Zip:

Insurance Release:

I authorize Gorham Family Dentistry to release to my insurance company any information relating to any and all insurance claims for treatment received. I authorize payment of dental benefits otherwise payable to me directly to Gorham Family Dentistry, P.A. I understand that I am financially responsible for any balance not paid my insurance company within 60 days of treatment.

Signed: Date:

Dental Information

	Yes	No		Yes	No
Do your gums bleed when you brush or floss?	☐	☐	Do you have earaches or neck pains?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you have clicking, popping, or discomfort in the jaw?	☐	☐
Does food or floss catch between your teeth?	☐	☐	Do you clench or grind your teeth?	☐	☐
Is your mouth dry?	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	Do you wear dentures or partials?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	Do you participate in active recreational activities?	☐	☐
Have you had any problems with previous dental treatment?	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐
Is your home water supply fluoridated?	☐	☐	Do you drink bottled or filtered water?	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	Do you have a TMJ disorder?	☐	☐
Are you interested in straightening your teeth?	☐	☐	Do you experience bad breath/bad taste in your mouth?	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐

Does dental treatment make you nervous? No_____ Slightly_____ Moderately_____ Extremely_____

Oral Hygiene

Do you use the following?	Yes	No
Toothbrush	☐	☐
Dental floss	☐	☐
Rubber tip	☐	☐
Other_____		

How often do you brush?_____

Frequency of dental cleanings:_____

Date of your last cleaning:_____

Your Toothbrush is: SOFT MEDIUM HARD ELECTRIC

Medical Information

Do you have or have you had any of the following?

	Yes	No		Yes	No
Autoimmune disease	☐	☐	Rheumatoid arthritis	☐	☐
Systemic lupus erythematosus	☐	☐	Asthma	☐	☐
Bronchitis	☐	☐	Emphysema	☐	☐
Sinus trouble	☐	☐	Tuberculosis	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	Chest pain under exertion	☐	☐
Chronic pain	☐	☐	Diabetes Type I or II	☐	☐
Eating Disorder	☐	☐	Malnutrition	☐	☐
Gastrointestinal disease	☐	☐	G.E. Reflux/persistent heartburn	☐	☐
Ulcers	☐	☐	Thyroid problems	☐	☐
Stroke	☐	☐	Glaucoma	☐	☐
Hepatitis, jaundice, or liver disease	☐	☐	Epilepsy	☐	☐
Fainting spells, or seizures	☐	☐	Neurological disorders	☐	☐
Sleep disorder	☐	☐	Mental health disorders	☐	☐
Recurrent infections	☐	☐	Kidney problems	☐	☐
Night sweats	☐	☐	Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐	Severe headaches/migraine	☐	☐
Severe or rapid weight loss	☐	☐	Sexually transmitted disease	☐	☐
Excessive urination	☐	☐	Arthritis	☐	☐
Anemia	☐	☐	Hemophilia	☐	☐
Low blood pressure	☐	☐	High blood pressure	☐	☐
AIDS or HIV infection	☐	☐	Abnormal bleeding	☐	☐
Cardiovascular disease	☐	☐	Angina	☐	☐
Arteriosclerosis	☐	☐	Heart Murmur	☐	☐
Heart attack if yes, when?_____	☐	☐	Congestive heart failure	☐	☐
Damaged heart valves	☐	☐	Mitral valve prolapse	☐	☐
Pacemaker	☐	☐	Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐	Blood transfusion	☐	☐
Artificial heart valve	☐	☐	Heart Surgery if yes, when?_____	☐	☐

Continuation of Medical Information….

Have you had an Orthopedic Joint Replacement (hip, knee, elbow, etc...)? YES NO

If yes, please answer the following questions:

What type of replacement?_____ Date replacement done:_____

Where did you have it done?_____ Doctor's Name:_____

Does the orthopedic surgeon recommend an antibiotic prior to dental appointment? YES NO

Have you had any complications with your replacement? YES NO If yes, please explain:_____

_____

Do you have any disease, condition, or problem not listed above that you think we should know about? YES NO

Please explain:_____

Have you had any placement of pins or rods? YES NO If yes, where:_____ date of placement:_____

Allergies

Are you allergic or have you had a reaction to any of the following?

	Yes	No		Yes	No
Local anesthetics	☐	☐	Aspirin or Codeine	☐	☐
Penicillin	☐	☐	Barbiturates/sedatives/sleeping pills	☐	☐
Sulfa Drugs	☐	☐	Metals	☐	☐
Latex	☐	☐	Other:_____		

Medications

Please list all **prescribed** or **over the counter** medications that you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

Cancellation Policy: Gorham Family Dentistry, P.A. views all appointments as a commitment between our patients and us. If you are unable to honor the commitment, we request 2 business days notice to allow another patient who is waiting for that time to be scheduled. If two appointments are not kept without the patient giving 2 business days notice in a twelve-month period the patient agrees to pay a fee equal to the greater of $50 or 15% of the cost of the planned treatment. If three appointments are not kept without the patient giving 2 business days notice in a twelve-month period, Gorham Family Dentistry, P.A. reserves the right to terminate the patient-doctor relationship.

Financial Policy: Payment is due when services are rendered. If you have insurance and we are able to estimate your insurance benefits, only the estimated co-payment is due when services are rendered. If insurance pays less than estimated, the patient is financially responsible for the balance. Payment is due within 30 days of the first statement sent for the balance. Gorham Family Dentistry will as a courtesy do our best to estimate what insurance will cover for each procedure and the frequency limitations per procedure however, knowing what insurance will cover and frequency issues is solely the responsibility of our patients.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or changes in my medications, I will inform the dentist at the next appointment.

_____

Signature of Patient, Parent, or Responsible Party Date