

# Patient Registration and Health History

Today's Date \_\_\_\_\_ Preferred Name \_\_\_\_\_  
**PATIENT'S NAME** \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Ext. # \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-mail address \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status \_\_\_\_\_  
Patient's Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
Spouse's Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Spouse's Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Spouse's Business Phone \_\_\_\_\_ Ext. # \_\_\_\_\_  
Spouse's Cell Phone # \_\_\_\_\_

Children (Names & Birth Dates) \_\_\_\_\_

Patient's Special Interests \_\_\_\_\_

**IF PATIENT IS A MINOR:** Age \_\_\_\_\_ School Attending \_\_\_\_\_ Grade \_\_\_\_\_

Mother's Name \_\_\_\_\_  
Mother's Address \_\_\_\_\_  
Father's Name \_\_\_\_\_  
Father's Address \_\_\_\_\_

*I hereby authorize Ruth H. Clemans, D.D.S. to treat the above named child and I accept responsibility for payment in full. I further authorize Dr. Ruth Clemans or any other employee or agent of Ruth H. Clemans D.D.S. P.C. to take any necessary radiographs for diagnosis and treatment purposes and for Dr. Ruth Clemans or any other employee or agent of Ruth H. Clemans D.D.S. P.C. to administer fluoride at recare visits.*

\_\_\_\_\_  
Guardian's Signature Date Relationship to Patient

## PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNTS

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SSN \_\_\_\_\_  
Phone #s: (work) \_\_\_\_\_ (home) \_\_\_\_\_ (cell) \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Address \_\_\_\_\_  
Driver's License \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Please check how you would prefer to pay. Forms of payment accepted:  
 cash  personal check  MasterCard / Visa

**Payment is due in full at the time of treatment unless prior arrangements have been made in writing.**

Do you have the benefit of dental insurance? Yes No

All treatment is to be paid in full at the time of service rendered, however if you do have the benefit of dental insurance, as a courtesy to you, we would be happy to prepare your claim for you. Please provide our receptionist with your current insurance information. The insurance company will be instructed to send your reimbursement directly to you.

**For insurance filing, please sign below:**  
I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

\_\_\_\_\_  
Signed (Patient or Parent/Guardian, if minor) Date

## PERSON TO CONTACT IN CASE OF EMERGENCY

Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

*Closest Relative Not Living With You*

Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

(OVER FOR HEALTH HISTORY)

## HEALTH HISTORY

1. Reason for Visit Today \_\_\_\_\_
2. Who may we thank for referring you? \_\_\_\_\_
3. Have you been a patient in the hospital during the past two years? \_\_\_\_\_
4. Have you been under the care of a medical doctor during the past two years? If "Yes," reason: \_\_\_\_\_  
\_\_\_\_\_
5. Physician's Name \_\_\_\_\_ Address \_\_\_\_\_
6. Physician's Phone # \_\_\_\_\_
7. Are you now taking any medication, drugs or pills? If "Yes," please list drug, dose & reason for taking drug:  
\_\_\_\_\_  
\_\_\_\_\_
8. Are you aware of being **ALLERGIC** to or have you ever reacted adversely to any medication or substance? Circle: YES NO If "Yes," please list  
\_\_\_\_\_
9. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item. Circle "P" if present now.
 

|  |   |   |
|--|---|---|
| Heart Failure ..... Yes / No             | Drug Addiction ..... Yes - P / No               | Hepatitis A (infectious) ..... Yes - P / No   |
| Heart Disease or Attack ..... Yes / No   | Stroke ..... Yes - P / No                       | Hepatitis B (serum) ..... Yes - P / No        |
| Angina Pectoris ..... Yes - P / No       | Artificial Joints (Hip, Knee, etc.) .. Yes / No | Hepatitis C ..... Yes - P / No                |
| Congenital Heart Disease ..... Yes / No  | Kidney Trouble ..... Yes - P / No               | Veneral Disease ..... Yes - P / No            |
| Heart Murmur ..... Yes - P / No          | Ulcers ..... Yes - P / No                       | A.I.D.S. .... Yes - P / No                    |
| High Blood Pressure ..... Yes - P / No   | Diabetes ..... Yes - P / No                     | H.I.V. Positive ..... Yes - P / No            |
| Arteriosclerosis ..... Yes - P / No      | Thyroid Problems ..... Yes - P / No             | Cold Sores / Fever Blisters .... Yes - P / No |
| Mitral Valve Prolapse ..... Yes - P / No | Glaucoma ..... Yes - P / No                     | Blood Transfusion ..... Yes - P / No          |
| Artificial Heart Valve ..... Yes / No    | Cosmetic Surgery ..... Yes / No                 | Hemophila ..... Yes - P / No                  |
| Heart Pacemaker ..... Yes / No           | Emphysema ..... Yes - P / No                    | Anemia ..... Yes - P / No                     |
| Heart Surgery ..... Yes / No             | Tuberculosis ..... Yes - P / No                 | Liver Disease ..... Yes - P / No              |
| Rheumatic Fever ..... Yes / No           | Asthma ..... Yes - P / No                       | Epilepsy or Seizures ..... Yes - P / No       |
| Arthritis ..... Yes - P / No             | Allergies or Hives ..... Yes - P / No           | Fainting or Dizzy Spells ..... Yes - P / No   |
| Rheumatism ..... Yes - P / No            | Radiation Therapy ..... Yes - P / No            | Nervousness ..... Yes - P / No                |
| Cortisone Medicine ..... Yes - P / No    | Chemotherapy ..... Yes - P / No                 | Psychiatric Treatment ..... Yes - P / No      |
10. Has your medical doctor ever said you have or had a cancer or tumor? If yes, please explain \_\_\_\_\_  
\_\_\_\_\_
11. Do you use tobacco products? \_\_\_\_\_  
If yes, what? \_\_\_\_\_ How much per day? \_\_\_\_\_  
Are you interested in quitting?  Yes / No
12. Are you allergic to latex? \_\_\_\_\_
13. Do you have problems with snoring or daytime sleepiness or sleep apnea? If yes, circle the ones which apply.
14. Do you have, or have you had, any disease, condition or problems not listed? If yes, please list:  
\_\_\_\_\_  
\_\_\_\_\_

### WOMEN ONLY:

15. Are you pregnant? \_\_\_\_\_
16. Are you nursing? \_\_\_\_\_
17. Are you taking the birth control pill? \_\_\_\_\_

### CONSENT

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

- The undersigned hereby authorizes Dr. Ruth Clemans or any other employee or agent of Ruth H. Clemans D.D.S., P.C. to take radiographs, study models, photographs or use any other diagnostic aids deemed appropriate by Dr. Clemans to make a thorough diagnosis of my, or my dependent's, dental needs. I also authorize Ruth Clemans, D.D.S. or any other employee or agent of Ruth H. Clemans D.D.S., P.C. to perform any and all forms of treatment, medication and therapy that may be indicated in connection with above named patient and further authorize and consent that Ruth Clemans, D.D.S. choose and employ such assistance as deemed appropriate.
- I understand the use of anesthetic agents embodies a certain risk including, but not limited to transient or permanent numbness.
- I understand and authorize the use of any of my, or my dependent's photographs, radiographs or models for educational, demonstrational or promotion use.
- I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, and that payment is due and payable at the time services are rendered; unless prior financial arrangements have been made in writing. I further understand that a 1 ½ % finance charge per month (18% annually) will be added to any balance over 30 days. In the event of default, I (We) promise to pay legal interest on the indebtedness together with such collections costs and reasonable attorney fees as may be required to effect collection of this note.
- In the unlikely event that I, the patient, or guardian of patient has a dispute with the doctor or the practice, I hereby agree that the dispute shall be settled by arbitration through the Better Business Bureau of Metropolitan Atlanta.
- By signing this consent form, I agree to be bound by its terms. I understand the terms of this consent. I state that I am authorized and have the capacity to enter into such an agreement. I acknowledge that all my questions have been satisfactorily answered.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Responsible Party For Patient \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

# Please Handle Me with Care

Put a check mark in the box next to the statement that concerns you or describes your problem. Then share this information with our dental team.

- I gag easily.
- I feel out of control when I'm lying down in the dental chair.
- I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.
- Pain relief is a top priority for me.
- I don't like shots ( or I've had a bad reaction to shots).
- Please tell me what I need to know about my mouth in order to make an informed decision.
- My teeth are very sensitive.
- I don't like the sound of that tool that makes the picking and scraping noise. It's like someone is scratching fingernails on a blackboard.
- I don't like cotton in my mouth.
- I hate the noise of the drill.
- Please respect my time. I don't want to be left sitting in the reception area.
- I want to know the cost up front. No money surprises please.
- I have difficulty listening and remembering what I hear while sitting in the dental chair.
- I have health problems and questions that we need to discuss.

## A "Handle Me with Care" Partnership

Now that you understand the importance of communicating all your fears and any issues of embarrassment and trust, let's look at making a "handle me with care" pact between you and your dental professionals. This simple, straightforward statement will make a big difference in how you are treated and how you feel about going to the dentist.

## THE HANDLE ME WITH CARE PARTNERSHIP PACT:

I ask that you honestly inform me of all my dental problems. I want you to make me aware of the best quality dentistry available today. Then we can discuss how I can make healthy choices that will work within my budget. I also want to know all the pain relief options available to me in your dental office, how each dental procedure will work, and how much of my time will be required.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

### DENTAL HEALTH INFORMATION

Thank you for providing us with important information that will help us better serve you.

Are you having any discomfort?  Yes  No

Sensitivity to hot, cold, sweets, chewing?  Yes  No

Does dental treatment make you nervous?  Yes  No

Have you experienced any of the following problems:

Bleeding Gums  Yes  No

Bad Breath  Yes  No

Soreness in jaw joint  Yes  No

Grinding/Clenching of teeth  Yes  No

Snoring  Yes  No

Sleep problems  Yes  No

Frequent headaches  Yes  No

Do you think your dental health affects your overall health?  Yes  No

Do you think it is important to have your teeth cleaned every six months?  Yes  No

Do you smoke or use tobacco in any form?  Yes  No

Do you drink coffee, tea, or red wine?  Yes  No

Are you interested in the prevention/treatment of bad breath?  Yes  No

On a scale of 1 to 10 with 10 being the highest rating:  
How important is your dental health to you?  
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?  
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?  
1 2 3 4 5 6 7 8 9 10

Is the brightness of your teeth important to you?  Yes  No

If I could change my smile I would make my teeth:  Yes  No

Whiter  Yes  No

Straighter  Yes  No

Close space  Yes  No

Replace Black Mercury fillings with tooth colored restorations  Yes  No

Repair chipped teeth  Yes  No

Less gum showing  Yes  No

Replace old crowns or caps that don't match  Yes  No

Do you prefer to save your teeth?  Yes  No

Have you ever had a special coating applied to your back teeth to protect from tooth decay?  Yes  No

Do you take a fluoride supplement?  Yes  No

Do you having any habits:

Biting cheeks/lips  Yes  No

Biting fingernails  Yes  No

Chewing ice  Yes  No

biting pencils/pens  Yes  No

Are you a mouth breather (versus a nose breather)?  Yes  No

Have you ever been told that you have gum disease?  Yes  No

Does anyone in your immediate family have gum disease?  Yes  No

Did you ever wear braces?  Yes  No

If Yes, do you still wear a retainer?  Yes  No

Have you (even as a child) experienced any trauma to your adult teeth? If Yes, please explain \_\_\_\_\_

When was the last time you had an oral cancer exam? \_\_\_\_\_ Date of last cleaning? \_\_\_\_\_

If there were a way to whiten your teeth for a very reasonable investment, would you be interested? \_\_\_\_\_

What is the most important thing to you about your future smile and dental health? \_\_\_\_\_

What is the most important thing to you about your dental visit today? \_\_\_\_\_

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\* You May Refuse to Sign This Acknowledgement \*

I \_\_\_\_\_, have received a copy of this  
office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name \*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but  
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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