IMPRESSIONS DENTAL

Adult Dental Registration & Treatment

Date ____________________

Patient Information

Patient Name ______________________________

Social Security # ______________________________

Address ______________________________

____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

☐ Male ☐ Female Date of Birth ____________________

Employer/School ______________________________

May we contact you by email or text message?

☐ Appointment Confirmation

☐ Billing Questions

Email Address ______________________________

How did you hear about Impressions Dental?

☐ Personal Referral ______________________________

☐ Mailing ☐ Phone Book ____________________

☐ Newspaper Ad ☐ Building sign ☐ Insurance Company

☐ Website ☐ Other ______________________________

Primary Dental Insurance

Subscriber Name ______________________________

Relationship to Patient ______________________________

Date of Birth ______________ SS/ID # ______________

Address (if different from patient) ______________________________

____

Subscriber's Employer ______________________________

Insurance Company ______________________________

Group # ______________________________

*All family accounts will be linked together for financial/insurance purposes unless otherwise requested.

Secondary Dental Insurance

Subscriber Name ______________________________

Relationship to Patient ______________________________

Date of Birth ______________ SS/ID# ______________

Address (if different from patient) ______________________________

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Subscriber's Employer ______________________________

Insurance Company ______________________________

Group # ______________________________

Assignment and Release

If you have dental insurance, please read below and sign.

I certify that I, and/or my dependant(s) have insurance coverage

with ______________________________ and assign directly to
Name of Insurance Company

Impressions Dental and its associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Impressions Dental and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

*All family accounts will be linked together for financial/insurance purposes unless otherwise requested.

____
Signature of patient or personal representative

____
Print name of patient or personal representative

______________________ ______________________
Date Relationship to patient

Contact Information

Phone: Home ____________________ Cellular ____________________ Work ____________________

May we call your work to reach you? ☐ Yes ☐ No E-mail ______________________________

EMERGENCY CONTACT INFORMATION

Name ____________________ Home Phone ____________________ Cellular ____________________

IMPRESSIONS DENTAL

Dental and Medical History Information

Dental History

Reason for today's visit ______________________________

Former Dentist ______________________ City/State ______________________

Date of last dental visit ______________________ Date of last dental x-rays ______________________

How often do you floss? ______________________ How often do you brush? ______________________

Please check all that apply:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette/pipe/cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain
- ☐ Jaw tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth/broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores/growths in mouth

Health History

Physician's Name ______________________ Date of Last Visit ______________________

Have you ever taken any medications containing bisphosphonates? This includes brands such as Fosamax, Actonel, Didronel, Boniva, Aredia, and Zometa. ☐ Yes ☐ No

Please check all that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Arificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent/bloody
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss/Gain

Do you wear contact lenses? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due Date ______________ Are you nursing? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis: ______________________

____

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other ______________

____

I authorize and give consent to perform dental services agreed between Impressions Dental and its associates and patient and/or parent or guardian to be necessary or advisable including the use of anesthesia and other medication as indicated. I certify to the accuracy of the above statements regarding my medical and dental history. Payment for all treatment and services rendered are my responsibility.

______________________ ______________________ ______________

Signature of patient, parent, guardian or personal representative — Printed name of patient, parent, guardian, or personal representative — Date