



## ADULT REGISTRATION FORM

### REGISTRATION INFORMATION

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Patient's Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

How do you wish to be addressed: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State of Issue: \_\_\_\_\_

Marital Status: Single  Married  Name of Spouse: \_\_\_\_\_ Work #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

Cell/Pager #: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### FINANCIAL RESPONSIBILITY

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Person financially responsible for this account: \_\_\_\_\_

If person is someone ***other than the patient:***

Mailing Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ \*Social Security Number: \_\_\_\_\_

Home #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Work #: \_\_\_\_\_ Cell/Pager #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I understand that I am financially responsible for all charges on the above mentioned patient. I also understand that payment is due on the day that services are rendered.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\*Please see office policies regarding social security numbers.

**PRIMARY/SECONDARY DENTAL INSURANCE INFORMATION (not health insurance)**

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Name of Individual that carries dental insurance (Policy holder): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ \*Social Security Number: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Company Phone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE INFORMATION (if applicable)**

Name of Individual that carries dental insurance (Policy holder): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ \*Social Security Number: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Company Phone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**INSURANCE AUTHORIZATION AND CONSENT FOR TREATMENT**

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I have reviewed the information on this form. It is accurate to the best of my knowledge. I understand that this information will be used by this office to help facilitate dental treatment. This information will be used in the strictest of confidence.

I authorize Generations Dental Care (Albert Binder, DMD and Christopher Binder, DMD, and its staff) to perform any necessary dental services that I may need during the course of diagnosis and treatment. I understand that Generations Dental Care will try to inform a patient prior to any changes in treatment, yet I also understand that there are times when those changes are unavoidable, and I authorize the practice to make those changes.

I authorize the insurance company(s) indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature for all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not they are paid by insurance.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\*Please see office policies regarding social security numbers.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I prefer to be called: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

In the event of an emergency, who should we contact? Name/Relationship: \_\_\_\_\_

Work #: \_\_\_\_\_ Cell/Pager #: \_\_\_\_\_

**MEDICAL INFORMATION**

Do you have a primary care physician? Yes / No If yes, Name of Physician: \_\_\_\_\_

Physician's Phone #: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Are you currently under the care of a Physician/Specialist? Yes / No If yes, why: \_\_\_\_\_

Physician/Specialist's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Are you currently taking any over-the-counter, herbal, and/or prescription medications? Yes / No

If yes, please list medications: \_\_\_\_\_

For Women: Are you taking birth control pills? Yes / No Name of Birth Control: \_\_\_\_\_

Are you pregnant? Yes / No Number of Weeks into pregnancy? \_\_\_\_\_ Are you nursing? Yes / No

**MEDICAL CONDITIONS**

Do you, or have you had any of the following (please check yes or no):

- |                                |  |                                 |  |
|--------------------------------|--|---------------------------------|--|
| Abnormal or Prolonged Bleeding | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hemophilia                      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Alcohol and/or Drug Abuse      | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis                       | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anemia                         | Yes <input type="checkbox"/> No <input type="checkbox"/> | Herpes/Fever Blisters           | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anxiety / Nervousness          | Yes <input type="checkbox"/> No <input type="checkbox"/> | High Blood Pressure             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Arthritis                      | Yes <input type="checkbox"/> No <input type="checkbox"/> | Auto Immune Deficiency          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Asthma                         | Yes <input type="checkbox"/> No <input type="checkbox"/> | Kidney Disease                  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Blood Disease                  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Liver Disease                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Blood Transfusion              | Yes <input type="checkbox"/> No <input type="checkbox"/> | Low Blood Pressure              | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bone Disorders                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Measles                         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chicken Pox                    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Psychiatric Problems            | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Colitis                        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Radiation Treatment             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes                       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Seizures                        | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Difficulty Breathing           | Yes <input type="checkbox"/> No <input type="checkbox"/> | Shingles                        | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Emphysema                      | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sickle Cell Disease / Traits    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Emotional Problems             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sinus Problems                  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Epilepsy                       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Stroke                          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Fainting Spells                | Yes <input type="checkbox"/> No <input type="checkbox"/> | Thyroid Problems                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Frequent Headaches             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tonsillitis                     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Glaucoma                       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tuberculosis (TB)               | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Growth Disorders               | Yes <input type="checkbox"/> No <input type="checkbox"/> | Ulcers                          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Hay Fever                      | Yes <input type="checkbox"/> No <input type="checkbox"/> | Venereal Disease                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Hearing Impairment             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hospitalizations / Surgeries    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Surgery/Heart Attack     | Yes <input type="checkbox"/> No <input type="checkbox"/> | If yes, for what reason & when? | _____  |

## OTHER MEDICAL CONDITIONS

Artificial Joints/Valves Yes  No  Cancer/Chemotherapy Yes  No   
Mitral Valve Prolapse Yes  No  Pacemaker Yes  No   
Rheumatic/Scarlet Fever Yes  No  Heart Murmur Yes  No   
Have you ever taken Phen-Fen (aka Redux or Pondimin)? Yes  No   
Have you ever been told you need to take antibiotics prior to dental treatment? Yes  No   
Do you have a persistent cough (greater than 3 weeks) and/or a cough that produces blood? Yes  No   
Have you ever taken medications for osteoporosis or to increase bone density (i.e. Actonel, Aredia, Boniva, Forteo, Fosamax, Zometa, )? Yes  No   
If you answered yes to any of the above, please list the reason and date: \_\_\_\_\_

## ALLERGIES

Are you allergic to any of the following:

Aspirin Yes  No  Codeine Yes  No  Local Anesthetics Yes  No   
Erythromycin Yes  No  Jewelry Yes  No  Latex Yes  No   
Metals Yes  No  Penicillin Yes  No  Seasonal/Hay Fever Yes  No   
Tetracycline Yes  No  Sulfa Yes  No

Please list anything else that you are allergic to: \_\_\_\_\_

## DENTAL HISTORY

When was the last time you were seen for the following:

A Dental Cleaning (Prophy): \_\_\_\_\_ An Examination by a Dentist: \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What type of bristles does your toothbrush have? Extra Soft  Soft  Medium  Hard

Do you visit the dentist twice a year? Yes  No

Do your gums bleed? Yes  No

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

If yes, what type, how often and for how long? \_\_\_\_\_

Have you ever had a serious or difficult problem associated with any previous dental work? Yes  No

If yes, what was the difficulty? \_\_\_\_\_

## DENTAL CONDITIONS

Have you ever had or experienced any of the following:

Teeth clenching Yes  No  Teeth grinding Yes  No   
Frequent headaches Yes  No  Ringing in the ears Yes  No   
Jaw Joint discomfort, clicking or popping Yes  No  Mouth breathing Yes  No   
Tender/sore head, neck or jaw muscles Yes  No  Speech problems Yes  No   
Trouble opening your mouth widely Yes  No

I affirm that this information is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff (dentists, hygienists, assistants) to perform any necessary dental services that I may need during the course of diagnosis and treatment. I understand that I am financially responsible for all charges whether or not they are paid by insurance.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Initials: _____ Date: _____	Initials: _____ Date: _____	Initials: _____ Date: _____
Initials: _____ Date: _____	Initials: _____ Date: _____	Initials: _____ Date: _____