GENERATIONS
DENTAL CARE

ADULT REGISTRATION FORM

REGISTRATION INFORMATION

Patient's Full Name: _____ Today's Date: _____

How do you wish to be addressed: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Marital Status: Single □ Married □ Name of Spouse: _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____

Home Phone #: _____ Work #: _____

Cell #: _____ How did you hear about us? _____

FINANCIAL RESPONSIBILITY

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 #: _____

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

-OVER PLEASE-

PRIMARY/SECONDARY DENTAL INSURANCE INFORMATION (not health insurance)

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: _____

CONSENT FOR TREATMENT AND INSURANCE AUTHORIZATION

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

GENERATIONS
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ADULT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I prefer to be called: _____ E-Mail Address: _____

EMERGENCY CONTACT INFORMATION

In the event of an emergency, who should we contact? Name: _____

Relationship: _____ Cell #: _____

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 ☐ No ☐	Hemophilia	Yes ☐ No ☐
Alcohol and/or Drug Abuse	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Herpes/Fever Blisters	Yes ☐ No ☐
Anxiety / Nervousness	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Auto Immune Deficiency	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Kidney Disease	Yes ☐ No ☐
Blood Disease	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐
Blood Transfusion	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐
Bone Disorders	Yes ☐ No ☐	Measles	Yes ☐ No ☐
Chicken Pox	Yes ☐ No ☐	Psychiatric Problems	Yes ☐ No ☐
Colitis	Yes ☐ No ☐	Radiation Treatment	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Seizures	Yes ☐ No ☐
Difficulty Breathing	Yes ☐ No ☐	Shingles	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐	Sickle Cell Disease / Traits	Yes ☐ No ☐
Emotional Problems	Yes ☐ No ☐	Sinus Problems	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Fainting Spells	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐
Frequent Headaches	Yes ☐ No ☐	Tonsillitis	Yes ☐ No ☐
Glaucoma	Yes ☐ No ☐	Tuberculosis (TB)	Yes ☐ No ☐
Growth Disorders	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐
Hay Fever	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐
Hearing Impairment	Yes ☐ No ☐	Hospitalizations / Surgeries	Yes ☐ No ☐
Heart Surgery/Heart Attack	Yes ☐ No ☐	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