

Sunset Dental  
**Patient Registration**

**Patient Name:**

Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

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

Student Status: \_\_\_\_\_ full-time \_\_\_\_\_ part-time Name of College/University: \_\_\_\_\_

Appointments are best confirmed by: Phone:(\_\_\_\_) Text:(\_\_\_\_) E-mail: (\_\_\_\_)

**Responsible Party: (If someone other than the patient)**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_ Cell phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work phone: \_\_\_\_\_ Ext. \_\_\_\_\_

**Primary Dental Insurance Information:**

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer name and address: \_\_\_\_\_

Insured SS#: \_\_\_\_\_ Insurance company/Phone #: \_\_\_\_\_

**Secondary Dental Insurance Information:**

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer name and address: \_\_\_\_\_

Insured SS#: \_\_\_\_\_ Insurance company/Phone #: \_\_\_\_\_

I hereby authorize Linda Selby, D.M.D., to release to my insurance company information necessary to process for payment or predetermination of benefits under my insurance plan. I hereby authorize payment directly to Sunset Dental; Linda Selby, D.M.D. of the insurance benefits otherwise payable to me.

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Date

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you \_\_\_\_\_

Pregnant/Trying to get pregnant?  Yes  No      Taking oral contraceptives?  Yes  No      Nursing?  Yes  No

Are you allergic to any of the following?

Aspirin     Penicillin     Codeine     Local Anesthetics     Acrylic     Metal     Latex     Sulfa drugs

Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine        | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia            | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments       | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease       | <input type="radio"/> Yes <input type="radio"/> No | Diabetes                  | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A           | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss         | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis               | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction            | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C      | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis             | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia                    | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded             | <input type="radio"/> Yes <input type="radio"/> No | Herpes                | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever            | <input type="radio"/> Yes <input type="radio"/> No |
| Angina                    | <input type="radio"/> Yes <input type="radio"/> No | Emphysema                 | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure   | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism                 | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout            | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures      | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol      | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever              | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve    | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding        | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash         | <input type="radio"/> Yes <input type="radio"/> No | Shingles                   | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint          | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst          | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia          | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease        | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma                    | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat   | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble              | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease             | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough            | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems       | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida               | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea         | <input type="radio"/> Yes <input type="radio"/> No | Leukemia              | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches        | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease         | <input type="radio"/> Yes <input type="radio"/> No | Stroke                     | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily             | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes            | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure    | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs          | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer                    | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma                  | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease          | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease            | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy              | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever                 | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis                | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains               | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure      | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis          | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis               | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur              | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints    | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths          | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker           | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease   | <input type="radio"/> Yes <input type="radio"/> No | Ulcers                     | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions               | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease     | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care      | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease           | <input type="radio"/> Yes <input type="radio"/> No |
|                           |  |                           |  |                       |  | Yellow Jaundice            | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

**Previous Dental Information:**

Patient Name \_\_\_\_\_

Previous dentist \_\_\_\_\_ City/State \_\_\_\_\_

Phone Number \_\_\_\_\_

Have you ever been treated for periodontal disease? \_\_\_ yes \_\_\_ no

Do you have any dental problems that are of immediate concern to you? please note:

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

Are you happy with the appearance of your teeth/gums/smile? \_\_\_ yes \_\_\_ no

Would you like to discuss enhancing the appearance of your smile? \_\_\_ yes \_\_\_ no

Would you like to discuss how to make your teeth WHITE? \_\_\_ yes \_\_\_ no

What don't you like about your smile? \_\_\_\_\_

How did you hear about our office? If a current patient referred you, we would like to thank them.

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

**Acknowledgment of Privacy practices**

Sunset Dental is required by Federal Law to have a policy regarding protected health information, and must provide patients the opportunity to review this policy if so requested. "Protected health information" includes demographic information such as address or date of birth, information gathered by providers, as well as other information – such as insurance information. This information may relate to the patient's past, present or future health condition. Any information where there is a reasonable basis to believe that it can be specifically identified with a patient is protected.

As a rule, patient information may be used to conduct treatment, to seek payment, or for healthcare operations without the patient's express written consent. However, other requests or uses of protected patient information require the patient's consent. The Notice of Privacy Practices describes patient rights and the duties of Sunset Dental with respect to protected health information, and is available in our waiting area and at the reception desk.

By signing below, I acknowledge that Sunset Dental has provided me with the opportunity to review the Notice of Privacy Practices, if requested.

\_\_\_\_\_  
Signature of Patient or personal Representative \_\_\_\_\_ Date