136 N. Ridge St., Suite C
Monroeville, OH 44847
(419) 465-2574
info@monroevilledental.com

PATIENT REGISTRATION

Name: _____ MI: ____ Last Name: _____
DOB: _____ Sex: ___ M ___ F
Marital Status: _____ SS#: _____ (not required for minors)
Home #: _____ Cell #: _____
Mailing Address: _____
Patient Employer: _____
Phone #:_____
Patient E-mail: _____
Referred by: _____
Hobbies: _____

INSURANCE INFORMATION

Name of Insured: _____
DOB: _____ SS#: _____
Relationship to Insured: ___ Self ___ Spouse ___ Child ___ Other: _____
Insurance Company: _____
Insurance Address: _____
Phone #: _____
Employer: _____
Phone #: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____
DOB: _____ SS#: _____
Relationship to Insured: ___ Self ___ Spouse ___ Child ___ Other: _____
Insurance Company: _____
Insurance Address: _____
Phone #: _____
Employer: _____
Phone #: _____

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RESPONSIBLE PARTY (if patient, no need to complete)

Name: _____ MI: ____ Last Name: _____
DOB: _____
Relationship to Patient: ___ Spouse ___ Parent ___ Other: _____
Address: _____
Phone #: _____
Employer: _____ Work #: _____

SPOUSE INFORMATION (if needed)

Name: _____ MI: ____ Last Name: _____
DOB: _____ Phone #: _____
Address: _____
Employer: _____ Work #: _____

PARENT INFORMATION (if needed)

Name: _____ MI: ____ Last Name: _____
DOB: _____ Phone #: _____
Address: _____
Employer: _____ Work #: _____

PARENT INFORMATION (if needed)

Name: _____ MI: ____ Last Name: _____
DOB: _____ Phone #: _____
Address: _____
Employer: _____ Work #: _____

Monroeville DENTAL

Patient Name: Birth Date: Date Created:

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

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

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed Yes No If yes

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:

X _____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices

Monroeville Dental Financial Policy

FINANCIAL POLICES: In our office, we do not want the ability to pay to be an issue for our patients. We want you to feel comfortable with us, and that includes feeling satisfied with the financial agreements regarding your dental care. We accept cash, check, Visa, MasterCard, Discover and Care Credit at the time of service.

1) **We expect copayment, deductible, and treatment plan estimate at the time of service.**
2) **A $50 return check fee for NSF.**
3) **We require 48-hour notice for appointment cancellation. A $50 cancellation fee will be charged if not given.**

Patients with Dental Insurance: I understand that my dental insurance is a contract between myself and my insurance carrier, not between Dr. Trask and the insurance carrier. I understand that I am responsible for the full amount of all dental fees incurred. I hereby authorize payment of the dental benefits be paid directly to Monroeville Dental. Any payments received by Dr. Trask from my insurance carrier will be credited to my account or refunded to me if I have paid the dental fees incurred.

Patient Name (Print): _____
Signature of Patient or Guardian: _____ Date: _____

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SMILE EVALUATION

1. Would you like your teeth to be straighter? ☐ Yes ☐ No
   Explain: _____

2. Do you have spaces between your teeth that you could like closed? ☐ Yes ☐ No
   Explain: _____

3. Have your teeth worn down? ☐ Yes ☐ No
   Explain: _____

4. Would you like the shape of your teeth changed? ☐ Yes ☐ No
   Explain: _____

5. Do you have missing teeth that you would like to replace? ☐ Yes ☐ No
   Explain: _____

6. Do you have old silver fillings that you would like to replace with tooth colored fillings? ☐ Yes ☐ No
   Explain: _____

7. Would you like your teeth to be whiter? ☐ Yes ☐ No

8. If you could change anything with your teeth & smile, what would you change?
   Explain: _____