



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 #: _____

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 <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 Problems <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 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: _____



Dental Information Release form (HIPPA Release)

Name: _____ Date of Birth: ____/____/____

Release of Information

- I authorize the release of information including the diagnosis, records, examinations, financials, appointments, and claims information. This information may be released to:
 - Spouse: _____
 - Child(ren): _____
 - Other: _____
 - Information is not to be released.

The **Release of Information** will remain in effect until terminated in writing.

Messages

Please call my home work cell phone

If unable to reach me:

You may leave a detailed message.

Please leave a message asking to return call

The best time to reach me is _____

Signed: _____ Date: _____