Northpointe SMILES

PATIENT REGISTRATION FORM

Patient Name _____ Date _____

❑ Single ❑ Married ❑ Widowed ❑ Divorced

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Cell Phone _____ E-mail _____

Social Security Number _____ Birth Date _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Person Responsible for Account _____

Dental Insurance Group _____ Group # _____

Employee Name _____

Social Security Number _____ Birth Date _____

Emergency Contact _____

Home Phone _____ Business Phone _____ Cell Phone _____

Referred to us by _____

Reason for leaving your last dentist _____

_____

_____

24445 TOMBALL PARKWAY, SUITE 150, TOMBALL, TX 77375
P. 832-422-5122 | WWW.SMILENORTHPOINTE.COM

MEDICAL QUESTIONNAIRE

ANY HISTORY OF:

Heart Problems	❑ YES	❑ NO	Bronchitis	❑ YES	❑ NO	Heart Valve Problems	❑ YES	❑ NO
High Blood Pressure	❑ YES	❑ NO	Fever Blisters/Herpes	❑ YES	❑ NO	Nose Obstruction	❑ YES	❑ NO
Rheumatic Fever	❑ YES	❑ NO	Stroke	❑ YES	❑ NO	Hypoglycemia	❑ YES	❑ NO
Emotional Stress	❑ YES	❑ NO	Thyroid Problems	❑ YES	❑ NO	Hyperglycemia	❑ YES	❑ NO
Asthma	❑ YES	❑ NO	Sinus Trouble	❑ YES	❑ NO	Prostate Problems	❑ YES	❑ NO
Blood Transfusions	❑ YES	❑ NO	Kidney or Liver Disease	❑ YES	❑ NO	Lung Disease	❑ YES	❑ NO
Hepatitis	❑ YES	❑ NO	Glaucoma	❑ YES	❑ NO	Contact Lenses	❑ YES	❑ NO
Artificial Joints	❑ YES	❑ NO	Allergies	❑ YES	❑ NO	Cancer	❑ YES	❑ NO
Heart Murmur	❑ YES	❑ NO	Prolonged Bleeding	❑ YES	❑ NO	Ulcers	❑ YES	❑ NO
Cortisone or ACT II	❑ YES	❑ NO	Epilepsy/Convulsions	❑ YES	❑ NO	Emphysema	❑ YES	❑ NO
Anemia	❑ YES	❑ NO	Arthritis	❑ YES	❑ NO	Fainting or Dizzy Spells	❑ YES	❑ NO
Tested Positive for HIV	❑ YES	❑ NO	Diabetes	❑ YES	❑ NO	Epinephrine Sensitivity	❑ YES	❑ NO

Do you have, or have you had, any diseases, conditions or problems not listed?

If yes, please specify: _____

Are you being treated by a physician now or have in the last six months? ❑ YES ❑ NO

Your Physician's Name _____

Are you taking any medications? ❑ YES ❑ NO (This includes over-the-counter drugs and prescription drugs)

If yes, please specify: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, please specify: _____

Any recent serious illnesses? ❑ YES ❑ NO If yes, please specify: _____

For women only: Are you pregnant? ❑ YES ❑ NO If yes, what month? _____

Are you nursing? ❑ YES ❑ NO

Are you on birth control? ❑ YES ❑ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

SIGN HERE

Patient Signature _____ Date _____

Consent:

I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective healthcare provider or agency who may release such information to you. I will notify this office of any changes in my health or medication. The undersigned hereby authorizes this office to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize this office to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that using anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event of default, I/We promise to pay legal interest on indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. All diagnostic aids and documentation are the property of this office. Original records may not be taken by the patient. All records are strictly confidential. Signing this form authorizes us to transfer records to another dentist. I have reviewed a copy of this office's Notice of Privacy Practices and I have been notified that I may have a copy.

SIGN HERE

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

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DENTAL QUESTIONNAIRE

Last _____First _____MI _____ Nickname _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? ❑ YES ❑ NO
2. Have you ever had any problems associated with previous dentistry? ❑ YES ❑ NO
3. Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely
4. Date of your last dental visit? _____
5. Have you ever been treated for any type of gum problems? ❑ YES ❑ NO
6. How often do you brush? _____Brush is: ❑ Soft ❑ Medium ❑ Hard
7. Are you happy with the appearance of your teeth? ❑ YES ❑ NO

   If no, what would you change? _____

8. Do you have, or have you ever had, any of the following?

Mouth Problems:		Teeth Problems:	
Bleeding/sore gums	❑ YES ❑ NO	Loose teeth	❑ YES ❑ NO
Unpleasant taste/bad breath	❑ YES ❑ NO	Sensitive to hot	❑ YES ❑ NO
Burning tongue/lips	❑ YES ❑ NO	Sensitive to cold	❑ YES ❑ NO
Frequent blisters/lips/mouth	❑ YES ❑ NO	Sensitive to sweets	❑ YES ❑ NO
Swelling/lumps in mouth	❑ YES ❑ NO	Sensitive to biting	❑ YES ❑ NO
Ortho treatment (braces)	❑ YES ❑ NO	Food stuck in teeth	❑ YES ❑ NO
Biting cheeks/lips	❑ YES ❑ NO	Clenching/grinding	❑ YES ❑ NO
Clicking/popping jaw	❑ YES ❑ NO	If so, when	_____
Difficulty opening or closing jaw	❑ YES ❑ NO	Shifting in bite	❑ YES ❑ NO
Headaches	❑ YES ❑ NO	Change in bite	❑ YES ❑ NO

9. Do you use the following?

Brush	❑ YES ❑ NO	Dental Floss	❑ YES ❑ NO
Fluoride Rinse	❑ YES ❑ NO	Other	_____

10. How would you rate your dental health? ❑ Excellent ❑ Good ❑ Poor

11. Any concerns or questions you have? _____

_____

These are things that are important to me about my dental health:

_____

_____

_____

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