New Patient Registration

Welcome! Thank you for selecting our team of professionals for your oral health needs.
To help us serve you better, please fill out this form as thoroughly as possible.
See our separate *Notice of Privacy Practices* for details on how this information is used.

ABOUT YOU

Form updated 3/14/2018

Name: _____ Preferred Name: _____ Date of Birth: _____
Last First

SSN: _____-_____-_____ ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Other

Home Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

How did you hear about our office? _____

CONTACT INFORMATION

Cell#: _____ Home#: _____ Work#: _____ ext. _____

Email: _____

In case of emergency, who should be notified? _____ Phone:_____

FINANCIALLY RESPONSIBLE PARTY

Name: _____ Relationship to Patient: _____ Phone: _____

Date of Birth: _____ SSN: _____-_____-_____ Driver's License No.: _____

Address: _____ City: _____ State: _____ Zip: _____

DENTAL INSURANCE INFORMATION

If you do not have dental insurance, skip to the next section.

Dental Insurance Company: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____ City:_____ State: _____ Zip: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Policy Holder's SSN: _____-_____-_____ ID #: _____ Group #: _____

MEDICAL INSURANCE INFORMATION

Medical insurance covers some dental procedures. By providing your medical insurance information, we may be able to save you money on dental treatment by utilizing your medical benefits.

Medical Insurance Company: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____ City:_____ State: _____ Zip: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Policy Holder's SSN: _____-_____-_____ ID #: _____ Group #: _____

If your insurance coverage changes, please notify our office prior to your next appointment to verify coverage and ensure proper filing of claims.

ORAL HEALTH HISTORY

Approximate date of last dental visit: _____ Approximate date of last full-mouth x-rays: _____

What are the reasons you came to see us today?

_____

Do you floss?
❑ Daily ❑ Semi-Weekly ❑ Weekly ❑ Rarely

What kind of toothbrush do you use?
❑Electric ❑Manual

Do you use mouthwash regularly?
❑ Yes ❑ No If yes, what kind: _____

Check any of the following conditions that may apply to you:

❑ Painful teeth or gums	❑ Chipped or worn teeth
❑ Sensitive teeth	❑ Sore jaw muscles
❑ Bleeding gums	❑ Past orthodontics
❑ Bad Breath	❑ Dental anxiety
❑ Gum disease (Periodontitis)	❑Stained teeth

Do you ever wake up with sore jaw muscles? ❑ Yes ❑ No

Do you or your partner think you may grind or clench your teeth at night? ❑ Yes ❑ No

Do you ever have problems opening or closing your jaw? ❑ Yes ❑ No

Do you ever have painful clicking or popping in your jaw joint? ❑ Yes ❑ No

Do you have any specific concerns about dental treatment? ❑ Yes ❑ No If yes, please explain:

_____

If you could wave a magic wand and change anything about your smile, what would you change?

_____

MEDICAL HISTORY

Are you under a physician's care now? ❑ Yes ❑ No Physician's name: _____ #: _____

Please list *any and all* medications, drugs, and supplements you take:

_____

Have you ever taken a bis-phosphonate for osteoporosis (such as Fosamax, Boniva, Actonel, etc.)? ❑ Yes ❑ No ❑ Maybe

a. Do you **currently** smoke or chew tobacco at all? ❑ Yes ❑ No

b. Have you **ever** smoked or chewed tobacco? ❑ Yes ❑ No

For either a or b (above), for how many years: _____

Women: Are/May you be pregnant? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin	❑Penicillin/Amoxicillin	❑Latex
❑Acrylic	❑Codeine/Hydrocodone	❑Metal
❑Sulfa drugs	❑Other: _____	

Have you ever had joint replacement surgery, heart surgery, or been told by a physician to take antibiotics before certain dental procedures? ❑ Yes ❑ No If yes, please explain:

_____

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

Aids/HIV	❑ Yes ❑ No	Cold Sores	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Radiation Treat.	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Alzheimer's	❑ Yes ❑ No	Drug Addiction	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Sickle Cell Anemia	❑ Yes ❑ No
Anaphylaxis	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Sinus Issues	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Epilepsy/Seizures	❑ Yes ❑ No	High Blood Press.	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Excess Bleeding	❑ Yes ❑ No	Irreg. Heartbeat	❑ Yes ❑ No	Tumors/Growths	❑ Yes ❑ No
Arthritis/Gout	❑ Yes ❑ No	Fainting Spells	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Artificial joint	❑ Yes ❑ No	Freq. Headaches	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Yellow Jaundice	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Hay Fever	❑ Yes ❑ No	Low Blood Press.	❑ Yes ❑ No		
Chemotherapy	❑ Yes ❑ No	Heart Attack	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No		
Chest Pains	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No		

Have you ever had any other serious illness that is not listed above? _____

Authorization and Release for Insurance Collections, and Agreement to Pay All Fees

I authorize and request my insurance company to pay my dental benefits directly to Dr. Rodriguez and Inman Park Dentistry. It is my responsibility to verify with the staff at Inman Park Dentistry the extent of my insurance coverage, and whether I will be charged "in" or "out" of network fees. *I understand that I am financially responsible for all charges, regardless of whether the charges are covered by my insurance or not.* I authorize the release of any information, including the diagnosis and records of treatment rendered, to my insurance company and other health care providers as necessary for the purposes of collecting payments for services rendered.

Photograph Release

I hereby authorize Inman Park Dentistry to take photographs of my face, jaws, and teeth. I understand that the photographs will be used to aid in proper diagnosis, for future treatment options, and may also be used for educational purposes. The photographs will not be used for promotional purposes without additional written consent.

Cancellation Policy

To ensure prompt care, minimal waiting times, and to allow for emergencies, your appointment time is reserved solely for you, and we do not double-book appointments. Therefore, we require a minimum of 2 business days notice if you need to cancel or change your appointment. **Insufficient notice, no-shows, or repeated cancellations may result in a $50/hour fee, and/or dismissal from our practice.**

Acknowledgement and Signature

I understand that I can seek treatment from any dental office, and that by choosing to have my treatment done at Inman Park Dentistry I agree to all the terms and conditions described above. I have completed this questionnaire accurately and completely and understand that providing false or misleading information can be dangerous to my health. It is my responsibility to inform Inman Park Dentistry of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ Date: _____

Amenities for your comfort
We offer these complimentary amenities to make your visit more comfortable: a television in each treatment room, Wi-Fi, noise-cancelling headphones, blanket, pillow, and a warm face towel. Nitrous Oxide (laughing gas), is available for an additional fee. Be sure to ask us for any of these services in order to make your stay more enjoyable.

Welcome to your new dental home! We strive to provide exceptional service to our patients. If you ever have an oral-health related question after hours or need to reach the doctor in an emergency, you may call (or text message) Dr. Rodriguez on his cell phone at 404.324.3202. He generally tries to return your call within an hour. You may also email him directly at: drarod@inmanparkdentistry.com

Thank you for your trust.

Alex Rodriguez DMD, and the entire team at Inman Park Dentistry