***Why do we ask these questions*?**
Answer: Because we are focused on wellness and helping you avoid unnecessary disease and higher health costs**!**

Explanation: Our office believes in the current science – that the mouth and general health are connected, also that many health problems are preventable and avoidable. That is why we believe that proper identification of health risk factors and condition can help us design an approach to your care that will improve your health through advanced preventive care, appropriate treatment strategies. Specific health issues such as cancer, heart disease airway size/quality, and the risk for many disease conditions are connected to the mouth and can affect oral health and vice-versa.

PATIENT REGISTRATION Part 1

PATIENTS NAME_____ **DOB**__/__/____ **TODAY'S DATE**__/__/____

Home Address	**City**	**State**	**Zip**
Home Phone #	***Please Circle One:*** Single Married Separated Widow		**Your Social Security Number**
Your Employer	**Occupation**		**Work Phone #**
If patient is minor we need Mother & Father's Names & Birth date			
Person responsible for account:	**YOUR Driver's License Number:**		
Name of spouse (or parent if minor)	**YOUR E-mail address**	**YOUR cell phone #**	
Spouse's (or parent's) employer	**Spouse's Soc. Sec. #**	**Work phone #**	
EMERGENCY INFORMATION			
Name, Address, & Telephone of A relative not living with you:			
How did you hear about our office?			
Reason for this visit?			

DENTAL INSURANCE INFORMATION (Primary Carrier)			**Dual insurance coverage, complete this for the second coverage (this office bills primary ins only)**		
Insured's name	**DOB**	**SS#**	Insured's name	DOB	SS#
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	**Policy #**		Group #		Local #

PRIVACY NOTICE ACKNOWLEDGMENT Part 2

The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand the dentist may release my dental, medical and other information about my dental treatment to third party payors and/or other health professionals in accordance with HIPPA regulations. I acknowledge full responsibility for the payment of all fees for services rendered. If desired, Whole Health Dentistry will file a claim on your behalf with your insurance company. I understand that I am responsible for any collectable charges that my insurance company denies payment. In addition, I agree to pay my deductible and any patient portion due at the time of service.

I have received a copy of the HIPAA Privacy Policy as required by law.

I prefer to be contacted via:

- ☐ home phone
- ☐ work phone
- ☐ email and US Mail (check all that apply).

X_____
Adult Patient Parent or Step-Parent Guardian

_____ _____
Date

PERSON RESPONSIBLE FOR ACCOUNT Part 3

Please check one:

- ☐ SELF or SPOUSE/PARTNER NAME _____
- ☐ PARENT OR GUARDIAN (IF UNDER 18) NAME_____

Responsible party has an account with this office: YES/NO

- ☐ I understand I am responsible for all charges incurred for services rendered, including any charges that are ultimately denied by my insurance company. I will pay my deductible and any patient portion owed at the time of service.

DENTAL HISTORY PART 4

Please check the following :	YES	NO
-Tooth Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐	☐
-Headaches, ear aches, neck or jaw joint pain	☐	☐
-Mouth ulcers or cold sores	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
	☐	☐

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

-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐

Please share the following dates:

-Your last cleaning ___ / ___

-Your last oral cancer screening ___ / ___

-Your last complete X-Rays ___ / ___

	YES	NO
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco? How much? For how long?	☐	☐

If I could change my smile, I would:

-Make my teeth whiter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Replace metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

What is the most important thing to you about your future smile and dental health? _____

_____

Why did you leave your previous dentist?

_____

_____

What is the most important thing to you about your dental visit today? _____

_____

Medical Systems Part 5

Please check all that apply. If none apply, please check "None of the above."

Cardiovascular	***ENT- Head & Neck***	**Other Diseases & Conditions**
☐ *Heart murmur/damaged heart valve*	☐ *Headache's*	☐ *Liver disease or Hepatitis*
☐ *Heart stent or angioplasty*	☐ *Migraine*	☐ *Tuberculosis*
☐ *Heart attack*	☐ *Tension*	☐ *AIDS /HIV positive*
☐ *Stroke*	☐ *Jaw joint popping/clicking*	☐ *Venereal Disease*
☐ *Angina, chest pain or discomfort*	☐ *Limited mouth opening*	☐ *Chronic fatigue /Fibromyalgia*
☐ *Congestive heart failure*	☐ *Jaw, Face, Neck or Back pain*	☐ *Arthritis or Rheumatisms*
☐ *Peripheral artery disease (PAD)*	☐ *Ear problems*	☐ *Kidney disease*
☐ *Swollen ankles*	☐ *Mouth breather*	☐ *Osteoporosis (bone loss)*
☐ *Bleeding/ clotting problems*	☐ *Hay fever or sinus problems*	☐ *Acid Reflux/Heartburn (GERD)*
☐ *High Blood pressure*	☐ *Persistent sore throat*	☐ *Frequent nausea/ vomiting*
☐ *High cholesterol*	☐ *Chronic cough*	☐ *Gastrointestinal disease*
☐ *Irregular or rapid heart beat*	☐ *Chronic hoarseness*	☐ *Ulcers, Colitis or Irritable bowel*
☐ *Heart pacemaker*	☐ *Unexplained numbness or pain*	☐ *Lung disease*
☐ *Other*	☐ *Difficulty chewing*	☐ *Asthma*
☐ ***None of the above***	☐ *Mouth sores 2+ weeks in duration*	☐ *Emphysema or COPD*
	☐ *Dentures with persistent sores*	☐ *Epilepsy*
	☐ *Difficulty swallowing*	☐ *Memory problems*
Endocrine Disorders	☐ *Difficulty moving jaw or tongue*	☐ *High stress or anxiety*
☐ *Thyroid problems*	☐ *Lump, swelling in mouth or neck*	☐ *Dental fear*
☐ *Pituitary or adrenal problems*	☐ *Numb mouth or tongue*	☐ *Depression*
☐ *Insulin resistant/ Pre-diabetes*	☐ *Other*	☐ *Immune System Disorder*
☐ *Diabetes - Type 1(insulin dependent)*	☐ ***None of the above***	☐ *Sjogren's syndrome*
☐ *Diabetes – Type 2(diet &medication)*		☐ *HPV positive (Human Papilloma)*
☐ *Diabetes – Type (insulin dependent)*		☐ *Chronic cough*
☐ *Diabetes is controlled*	**Sleep**	☐ *Other*
☐ *Other*	☐ *Snoring*	☐ ***None of the above***
☐ ***None of the above***	☐ *Daytime tiredness*	
	☐ *Poor sleep*	**General Health Women**
	☐ *Gasp for air*	☐ *Birth control pills*
Cancer	☐ *Stop breathing during sleep*	☐ *Pregnant*
☐ *Cancer or tumor*	☐ *Large or thick neck*	☐ *1-3mo 3-6mo 6-9mo*
☐ *Oral cancer*	☐ *Obstructive Sleep Apnea*	☐ *Planning pregnancy*
☐ *Chemotherapy*	☐ *CPAP*	☐ *Nursing mother*
☐ *Radiation therapy*	☐ *Oral sleep appliance*	☐ *Menopause*
☐ *Other*	☐ *Not currently using any therapy*	☐ *Hysterectomy*
☐ ***None of the above***	☐ *Other*	☐ ***None of the above***
	☐ ***None of the above***	

Patient Medications, Supplements & Surgeries Part 6

Please check all that apply, If none apply, please check "None of the above."

Do you take, or have ever taken any of the following:	List the medications that you are currently taking:
☐ Breathing medications	
☐ Antidepressants ☐ Antianxiety	
☐ Sleeping pills	
☐ Aspirin or blood thinners	
☐ IB / Tylenol / Acetaminophen	
☐ Dilantin or seizure medications	
☐ Immunosuppressant's	
☐ Calcium channel blockers	
☐ Blood Pressure Medication	
☐ Other	

Surgeries	Do you have any allergies or reaction to:	
☐ Joint or Bone Surgery	☐ Aspirin	☐ Penicillin
☐ Heart Surgery	☐ Erythromycin	☐ Codeine
☐ Cancer	☐ Latex	☐ Metals
☐ Other	☐ Local Anesthetic	☐ Other
	☐ Nitrous Oxide	☐ **None of the above**

Nutrition & Lifestyle Part 7

Please check all that apply. If none apply, please check "None of the above."

What is your diet rating		
☐ Good	☐ Eating disorders	☐ Do NOT exercise regularly
☐ Fair	☐ Taking dietary supplements	☐ Lemon sucking
☐ Poor	☐ Drinking carbonated /sweetened beverages	☐ Use gum, cough drops or breath mints regularly

Tobacco, Alcohol & Drugs Part 8

Please check all that apply. If none apply, please check "None of the above."

☐ Women: Two or more drinks per day average	☐ Current use of smokeless tobacco- Type_____	☐ Recreational drugs
☐ Men: Three or more drinks per day average	☐ Amount per day?_____	☐ **None of the above**
☐ Current smoker-Packs per day? _____	☐ Former user -When did you quit? _____	
☐ Former smoker- When did you quit? _____	☐ Chronic exposure to 2nd hand Smoke?	

Patient Signature (parent if Child) **Doctor Signature** **Date**

Additional Notes:

Family History Part 9

If a family member has or had a condition listed below: What age? Alive or Deceased

Medical condition	Mom	Dad	Sister	Brother	Daughter	Son	Grandparents	
Heart attack								
Stroke								
Diabetes-Type II								
Alcoholism								
Anemia								
Aortic aneurysm								
Alzheimer's								
Arthritis								
Asthma								
Autoimmune disorder								
Bleeding problems								
Carotid artery disease								
Cancer								
Depression								
Diabetes- Type I								
Other genetic disease								
High cholesterol(hyperlipidemia)								
High blood pressure (hypertension)								
Immunosuppressive disorders								
Kidney disease								
Osteoporosis								
Peripheral vascular disease								
Epilepsy (seizure disorder)								
Substance abuse								
Thyroid disorder								
Smoking								
Sleep apnea								
Polycystic ovary disease								
Coronary bypass								
Coronary stents								
Mini strokes								
Gum disease								
Bad teeth								

Additional Notes:

Financial Information & Options

Our commitment to our patients is to help them have the most beautiful smile with optimum health and function. We consider our patients friends. And it is our goal that they leave our office feeling as if they have been treated like a guest in our home.

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED PROTION.

Methods of Payment

1. Cash, Check or Credit Card (Visa, Master Card, Discover, American Express)
2. Dental Insurance (described below)
3. If need we also have outside financial plans

Dental Insurance

1. We will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer and the insurance company. **Please bring in a copy of your benefit booklet if you would like us to help interpret your benefits.**
2. As a courtesy, we will file your insurance for you. We ask that the deductible and amount we estimate your insurance will not cover be paid at the time of service. After the insurance pays, you will be billed for any remainder due.
3. Not all services are a covered benefit in all insurance contracts. Some insurance companies arbitrarily select certain services they will cover. The benefits are dependent on the plan your employer chooses for you.

Related Information

1. Returned checks and balances older than 60 days may be subject to additional collection fees and interest charges of 1.5% per month, or 18% annually. These additional fees will be applied to the unpaid balance at the end of the month
2. In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court cost and collection agency fees.)
3. Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. **A 48-hour notice is needed to avoid a charge.**

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered. I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

Name (Please print) _____

Signature _____ **Date** _____