ElevenEightySeven Dental

Dr. Michael J. Rezsofi, D.D.S

REGISTRATION AND HEALTH HISTORY FORM

PATIENT INFORMATION:

Name(last)________________________ (first)____________________ (Nickname)_______________

SSN:____________________________ Address:_______________________________Apt:____

City:_______________ State:_______ Zip:____________ Email Address:______________________

Mobile#:____________________ Text preference: Y/N ____ Home#_________________________

Work#:__________________ DOB:____/____/______ Sex:_____ Appointment Date:_________

Reason for visit:____

Has any family member received treatment in this office? Y / N Name:___________________

How did you hear about us?________________ Preferred appointment time: Morning/ Afternoon

EMERGENCY CONTACT:

Name:________________________________ Phone #:_______________________________

Address:_____________________________________ Relation to patient:___________________

RESPONSIBLE PARTY:

Name (last)_____________________________ (first)______________________________________

Billing Address:___________________________ City:_______________ State:__________ Zip:________

Relation to patient:________________________ SSN:_____________________ DOB:____________

Spouse Name: (last)_________________ (first)____

Employer:____ Phone:______________________

DENTAL INSURANCE:

Insured's Name:_______________________________ Insurance Company:_________________

Insurance Company Address:____________________ City:__________ State:________ Zip:_______

Insured's Employer:____

Insured's SSN:____-____-____-______ Group #:_______________ Member ID:__________________

ElevenEightySeven Dental

Dr. Michael J. Rezsofi, D.D.S

DENTAL HISTORY **IT IS IMPORTANT FOR US TO KNOW YOUR DENTAL HISTORY. THESE FACTS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH AND WILL BE KEPT CONFIDENTIAL.**

How long has it been since you have seen a dentist? __________ Approximate date: __________

Dentist name: ____________________ City: __________ State: ______ Phone: ______________

If you could change anything about your teeth, what would it be? ______________________

____

Please rank the following in order in which they would prevent you from having dental treatment (1-4)

Fear of pain # ____ **Lack of concern #** ____ **Cost of treatment #** ____ **Missing work time#** ____

Are you currently having problems? What are those problems?_________________________________	Yes No
Are your teeth sensitive to hot, cold, sweets, pressure?	Yes No
Are you unhappy with the appearance of your teeth?	Yes No
Is your present dental health poor?	Yes No
Are you apprehensive about dental treatment?	Yes No
Do your gums bleed, or feel tender or irritated?	Yes No
Have you had any periodontal (gum) treatments?	Yes No
Do you regularly use dental floss?	Yes No
Have you worn braces on your teeth? (orthodontics) Name of doctor:________________________Date:__________	Yes No
Are you aware of grinding or clenching your teeth?	Yes No
Do you have headaches, earaches, or neck pain?	Yes No
Are you aware of any possible sleeping disorder? (snoring)	Yes No
Do you wear dentures? (partial or full)	Yes No
Are you happy with your dentures?	Yes No

ElevenEightySeven Dental

Dr. Michael J. Rezsofi, D.D.S

GENERAL HEALTH HISTORY

PLEASE CIRCLE YES OR NO IF YOU CURRENTLY SUFFER FROM ANY OF THE FOLLOWING, AND LIST CONDITIONS IF NECESSARY:

Condition	
Cardiovascular disease (heart trouble, heart attack, stroke, coronary insufficiency, damaged coronary heart valves, heart murmur, artificial heart valve, pacemaker, etc.)	Yes No
High blood pressure medication name:____________________________	Yes No
Low blood pressure medication name:____________________________	Yes No
Diabetes medication name:_______________________________________	Yes No
Kidney trouble medication name:_________________________________	Yes No
ADD/ADHD medication name:____________________________________	Yes No
Any condition that would require premedication? (such as hip/ knee replacement) List condition:____	Yes No
Tuberculosis	Yes No
Abnormal bleeding associated with previous surgery, extraction, or trauma	Yes No
Any other disease, condition, or problem not listed above that we should know about?	Yes No
Are you currently under a physicians care? If yes, what condition?____	Yes No
Are you currently taking any other medications not listed above? ____ ____	Yes No
Are you allergic to, or have you had adverse reactions to any drugs or medications? List medications:____________________________ ____	Yes No
Women Only: Are you pregnant?	Yes No
Are you nursing?	Yes No

ElevenEightySeven Dental

Dr. Michael J. Rezsofi, D.D.S

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Please print name: ____

Signature: ____

FOR OFFICE USE ONLY We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___Individual refused to sign
___Communication barriers prohibited obtaining
___An emergency situation prevented us from obtaining
___Other (please specify) :______________________
____

RESPONSIBILITY AND CONSENT STATEMENT

Our staff will review this Responsibility and Consent Statement with you before signing.

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, and x-rays. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate. Occasionally the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and its fee.

Signature of Patient: ______________________________ Date: __________________

Signature of Dentist: ______________________________ Date: __________________