PROSPECT Dental

Patient Registration Form

About You

Patient Name: _____ (LAST / FIRST / MI)

What You Prefer To Be Called: _____

☐ Male ☐ Female SS#: _____

Date Of Birth: _____ Age: _____

Mailing Address: _____

_____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Referred by: _____

☐ I WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS VIA TEXT MESSAGE

E-mail: _____

☐ I WOULD LIKE TO RECEIVE CORESPONDENCE VIA E-MAIL

Employer: _____ Occupation: _____

Employer's Address: _____

_____ Phone #: _____

Status: ☐ Minor ☐ Single ☐ Married
☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Insurance Info

Primary Dental Insurance

Co. Name: _____ Insured's ID #: _____

Address: _____

Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's name: _____ Insured's DOB: _____

Insured's Employer: _____ Relation: _____

Secondary Dental Insurance

Co. Name: _____ Insured's ID #: _____

Address: _____

Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's name: _____ Insured's DOB: _____

Insured's Employer: _____ Relation: _____

Account Info

Person responsible for the account

Name: _____

Relation: _____ SS #: _____

Billing Address: _____

_____ Work Phone #: _____

Driver's License #: _____

Payment method

☐ Cash ☐ Check ☐ Credit Card #: _____

☐ Care Credit#: _____

(_____ INITIALS)I herby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Emergency Contact

Whom should we contact? _____ NAME

Relation: _____ **Home Phone #:** _____

Work Phone #: _____ **Cell Phone #:** _____

Who is your medical doctor? _____

Medical Doctor's Phone #: _____

1120 E. Central Road,
Arlington Heights, IL 60005
ph: (847) 890-4444
www.prospectdental.net

PLEASE CONTINUE ON BACK

PROSPECT Dental

Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ No ☐ Yes/How long? _____

Please indicate any of the following problems:

☐ Discomfort, clicking or popping in jaw ☐ Bad breath ☐ Ringing in ears ☐ Broken/Chipped tooth
☐ Red, swollen or bleeding gums ☐ Lost/Broken filling(s) ☐ Teeth grinding ☐ Blisters/Sores in/around the mouth
☐ Sensitive tooth, teeth or gums ☐ Locking jaw ☐ Stained teeth ☐ Snoring
☐ Other _____

Do you require pre-medication? ☐ Yes ☐ No ☐ I don't know

Previous Dentist: _____ Phone #:_____Last Dental Exam:___/___/___ Last Dental X-rays: ___/___/___

Times a day you brush?_____Times a week you floss?_____What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile (worst) 1 2 3 4 5 6 7 8 9 10 (best)

How can we improve your smile? _____

Medical History

What medications are you taking?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis
☐ Other(s), please list: _____

Have you ever taken: Bisphophonates (ex. Aredia/Fosamax) ☐Yes ☐No Phen-fen/Redux ☐Yes ☐No

Do you have/had any of the following:

☐ Alcohol/Drug Abuse	☐ Chest Pains	☐ Heart Attack	☐ Liver Problems	☐ Sinus Problems
☐ Anemia	☐ Congenital Heart Defect	☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Stomach Prob
☐ Arthritis	☐ Cosmetic Surgery	☐ Heart Murmur	☐ Nervousness	☐ Stroke
☐ Artificial Bones/Joints	☐ Diabetes/Hypoglycemia	☐ Heart Surg./Pacemaker	☐ Psychiatric Prob.	☐ Thyroid Problems
☐ Artificial Valves	☐ Difficulty Breathing	☐ Hepatitis	☐ Respiratory Prob.	☐ Tuberculosis TB
☐ Asthma	☐ Emphysema	☐ High/Low Blood Pressure	☐ Rheumatic Fever	☐ Ulcers
☐ Back Problems	☐ Epilepsy	☐ HIV+/AIDS	☐ Rheumatism	☐ Venereal Disease
☐ Bleeding Problems	☐ Fainting/Seizures	☐ Jaw Problems TMJ/TMD	☐ Scarlet Fever	☐ X-ray or Cobalt Treatment
☐ Cancer/Tumors	☐ Frequent Neck Pain	☐ Kidney Problems	☐ Severe/Freq. Headaches	
☐ Chemotherapy	☐ Glaucoma	☐ Leukemia	☐ Shingles	

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following?

☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics ☐ Foods ☐ Acrylic ☐ Metal
☐ Sulfa drugs ☐ Others: _____

Do you use tobacco? ☐No ☐Yes/How used?_____ How much? _____ How long? _____

Please rate your general health from 1-10 _____

For women: 1. Are you taking birth control pills? ☐ Yes ☐ No 2. Are you pregnant? ☐ Yes/How Long?_____☐ No
3. Are you nursing? ☐ Yes ☐ No

UPDATE
(office use)

Initials Date
Comments
Initials Date
Comments
Initials Date
Comments

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is in my responsibility to inform this office of any changes to the information I have provided.

(INITIALS) I acknowledge that I have received a copy of the Summary of Privacy Notice

Signature: _____ Date: _____

☐ Adult ☐ Parent/Guardian ☐ Spouse