WELCOME TO FOSTER CITY DENTAL CARE!

Please fill out our Dental Registration & Health History Forms so we may serve you better.

PATIENT INFORMATION

Today's Date _____ Name _____
(Last) (First) (Initial)

Address _____
(Street) (Apt/Unit) (City) (State) (ZIP)

Home Phone # _____ Cell Phone # _____ Email _____

Employer Name _____ Occupation _____ Work Phone # _____

Soc. Sec. # _____ Age _____ Birthdate _____ ID Verified: ❑ Yes ❑ No

Sex: ❑ Male ❑ Female Are you: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

In case of emergency, contact _____
(Last) (First) (Tel #) (Relationship to Patient)

How did you initially hear about our Practice? _____

Do you have dental insurance? ❑ No ❑ Yes Do you have Medicare-Part B insurance? ❑ No ❑ Yes (see the Front Desk)

PRIVACY ACKNOWLEDGMENT

I acknowledge that I am over the age of 18 and have received a copy of the Notice of Privacy Practices dated September 23, 2013. By signing below I give my consent and permission for the use & disclosure of my protected health information as specified in the Notice of Privacy Practices for treatment, payment and health operations or as required by law. Furthermore I understand that I have the right to request restrictions (in writing) on disclosure to any family members, other relatives, close personal friends, or any other person(s) identified by me.

_____ _____
Signature of Patient (if over age 18) Date

***NOTE: If the patient is a minor child (under age 18), a Parent/ Legal Guardian who is legally responsible for the minor child's medical/dental care must sign this privacy acknowledgment on the minor patient's behalf.**

_____ _____
Signature of Parent/Legal Guardian (patient under age 18) Printed Name of Parent/Legal Guardian

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges including any unpaid/denied insurance claims incurred at Foster City Dental Care and that the costs of treatment and co-payments quoted to me are estimates only which are not a guarantee of insurance coverage and/or insurance payment. I further understand that all payments, co-payment and unpaid balances not covered by dental insurance are due and payable from me on the day of treatment and agree to abide by this policy. I permit the use of my signature on all insurance claim submissions and authorize/request the dental insurance company to pay Foster City Dental Care directly for all such claims on my behalf that would otherwise be payable to me. I understand that Foster City Dental Care will bill my insurance carrier(s), if any, as a courtesy and any discrepancies are my responsibility to resolve.

_____ _____
I Agree To Financial Responsibility For All Charges For This Account Date

If You Are The Financially Responsible Party For This Account Continue To Back Of Page For Health Information.

If Someone Else Will Be Financially Responsible For Your Account Please Have Them Fill Out The Information Below As Acknowledgment Of Their Responsibility On Your Behalf

Who is responsible for this account? _____
(Last) (First) (Relationship to Patient)

Address _____
(Street) (Apt/Unit) (City) (State) (ZIP)

Home Phone # _____ Cell Phone # _____ Email _____

Employer Name _____ Occupation _____ Work Phone # _____

Soc. Sec. # _____ Age _____ Birthdate _____ ID Verified: ❑ Yes ❑ No

_____ _____
Signature Of The Person Who Will Be Financially Responsible For This Account Date

Dental History

Reason for today's visit _____ Date of last dental exam _____

Former Dentist _____ Date of last x-rays _____

Condition	Yes	No	Don't Know	Condition	Yes	No	Don't Know	Condition	Yes	No	Don't Know
Bad breath	☐	☐	☐	Periodontal (gum) treatment/surgery	☐	☐	☐	Loose/broken teeth	☐	☐	☐
Biting of lips/cheeks	☐	☐	☐	Scaling/root planing (deep cleaning)	☐	☐	☐	Loose/broken filling(s)	☐	☐	☐
Fingernail biting	☐	☐	☐	Gums bleeding/tender/swollen	☐	☐	☐	Sensitivity to hot	☐	☐	☐
Clicking/popping of jaw	☐	☐	☐	Difficulty opening/closing jaw	☐	☐	☐	Sensitivity to cold	☐	☐	☐
Pain/discomfort of jaw	☐	☐	☐	Food collection between teeth	☐	☐	☐	Sensitivity to sweets	☐	☐	☐
Sores or growths in mouth	☐	☐	☐	Cigarette/cigar/pipe smoking	☐	☐	☐	Sensitivity to biting	☐	☐	☐
Orthodontic treatment	☐	☐	☐	Grinding/clenching of teeth	☐	☐	☐		☐	☐	☐

How often do you brush? _____ How often do you floss? _____

Have you had any serious/difficult problems associated with any previous dental treatment? ☐ No ☐ Yes

Medical History

Physician's Name: _____ Date of last visit _____

List All Past Surgeries: _____

Condition	Yes	No	Don't Know	Condition	Yes	No	Don't Know	Condition	Yes	No	Don't Know
AIDS/HIV	☐	☐	☐	Fainting or dizziness	☐	☐	☐	Scarlet fever	☐	☐	☐
Anemia	☐	☐	☐	Glaucoma	☐	☐	☐	Shortness of breath	☐	☐	☐
Arthritis/rheumatism	☐	☐	☐	Headaches	☐	☐	☐	Sinus trouble	☐	☐	☐
Artificial heart valve	☐	☐	☐	Heart murmur	☐	☐	☐	Skin rash	☐	☐	☐
Artificial joints	☐	☐	☐	Heart problems	☐	☐	☐	Special diet	☐	☐	☐
Asthma	☐	☐	☐	Hepatitis Type _____	☐	☐	☐	Stroke	☐	☐	☐
Back problems	☐	☐	☐	Herpes	☐	☐	☐	Swollen feet/ankles	☐	☐	☐
Bisphosphonate treatment (Zometa or Aredia)	☐	☐	☐	High blood pressure	☐	☐	☐	Swollen neck glands	☐	☐	☐
				Jaundice	☐	☐	☐	Thyroid problems	☐	☐	☐
Bleeding abnormally, with surgery/extraction	☐	☐	☐	Jaw pain	☐	☐	☐	Tonsillitis	☐	☐	☐
				Kidney disease	☐	☐	☐	Tuberculosis	☐	☐	☐
Blood disease	☐	☐	☐	Liver disease	☐	☐	☐	Tumor or growth on head or neck	☐	☐	☐
Cancer	☐	☐	☐	Low blood pressure	☐	☐	☐				
Chemical dependency	☐	☐	☐	Mitral valve prolapse	☐	☐	☐	Ulcer	☐	☐	☐
Chemotherapy	☐	☐	☐	Nervous problems	☐	☐	☐	Venereal disease	☐	☐	☐
Circulatory problems	☐	☐	☐	Nursing	☐	☐	☐	Weight loss/unexplained	☐	☐	☐
Congenital heart lesions	☐	☐	☐	Pacemaker	☐	☐	☐	Do you wear contact lenses?	☐	☐	☐
Cortisone treatments	☐	☐	☐	Pregnant, due _____	☐	☐	☐				
Cough, persistent/bloody	☐	☐	☐	Psychiatric care	☐	☐	☐	Exposed to or are experiencing symptoms of any infectious airborne transmissible disease in the last 30 days?	☐	☐	☐
Diabetes	☐	☐	☐	Radiation treatment	☐	☐	☐				
Emphysema	☐	☐	☐	Respiratory disease	☐	☐	☐				
Epilepsy	☐	☐	☐	Rheumatic fever	☐	☐	☐	Other _____	☐	☐	☐

Medications

Are you currently taking any medications? ☐ **Yes** ☐ **No**

If Yes, please list the medications: _____

_____

_____

_____

Pharmacy Name _____

Location _____ Phone _____

Allergies

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Aspirin	☐	☐	☐	Local Anesthetic
☐	☐	☐	Barbiturates	☐	☐	☐	Penicillin
☐	☐	☐	Codeine	☐	☐	☐	Sulfa
☐	☐	☐	Iodine	☐	☐	☐	Other _____
☐	☐	☐	Latex	☐	☐	☐	_____
				☐	☐	☐	_____

To Be Completed By Patient

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist, any member of his/her staff or the practice responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient (Parent/Legal Guardian if under age 18)

To Be Completed By Attending Doctor

The dental and medical history outlined on this registration form by our patient or their duly authorized representative has been reviewed by myself and any conditions that could/would be affected by dental treatment has been identified and discussed.

_____

Signature of Attending Doctor Date