

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) (Middle 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 Foster City Dental Care's 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 consent to the dental practice using any of the contact methods listed above (including texting and emailing) regarding appointments, appointment reminders, treatment, insurance and my account. I understand that I can amend or withdraw my consent at any time.

Signature of Patient (if over age 18)

Date

Signature of Parent/Legal Guardian (if 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

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

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

Former Dentist _____ Date of last x-rays _____

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

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

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				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetic
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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) _____ Date _____

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 _____