UPPER GWYNEDD DENTAL ARTS

Preventative, Cosmetic, Implant, & Advanced Restorative Dentistry
1117 South Broad Street
Lansdale, PA 19446
215-855-3400
www.ugdentalarts.com

REGISTRATION FORM

Section I: Patient Information

Date_______________

Name:_______________________________________ I Prefer to be called: ____________________
Address:_______________________________City:______________State:________Zip_______________
Phone (_____)_______________ Work Phone (____) ______________ Cell Phone (_____)_______________
The best way to contact me is: ☐ Email ☐ Text Message ☐ Call Home Phone ☐ Call Cell Phone ☐ Call Work Phone
Date of Birth:______________ Social Security Number:______________________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_________________________ City/State________________________ ☐ FT ☐ PT
Spouse or Parent's Name:_______________________ Employer_______________ Work Phone____________
Whom may we thank for referring you? ____
Person to contact in case of emergency_____________________________ Phone_______________
Email Address__________________________________ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:____ Relationship to Patient: ________________
Address:____
City:__________________________ State:_________ Zip:____________ Phone: (____)______________
Employer_____________________ Work Phone (____)_______________ SSN#________________________

Section III Insurance Information

Name of Insured___________________________DOB_____________Relationship to Patient ____________
SSN#:_____________________ Name of Employer:____________________ Work Phone: (____)____________
Address of Employer:_____________________________City_________________State:_______Zip __________
Insurance Company_________________________Grp #____________________ ID#_____________________
Ins Co Address:_______________________________________ Ins Co. Phone:________________________

----------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING -----------

Name of Insured___________________________DOB_____________Relationship to Patient ____________
SSN#:_____________________ Name of Employer:____________________ Work Phone: (____)____________
Address of Employer:_____________________________City_________________State:_______Zip __________
Insurance Company_________________________Grp #____________________ ID#_____________________
Ins Co Address:_______________________________________ Ins Co. Phone:________________________

INSURANCE ASSIGNMENT & RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I am aware that I am financially responsible for any balance(s) due. Insurance reimbursement is a contract between the patient and their insurance company. We cannot accept responsibility for collecting insurance claims or for negotiating disputed claims.

SIGNED:____ DATE: __________________

I understand that I am responsible for payment of my account within thirty (30) days unless other arrangements have been made in advance. I also understand that expenses incurred for the use of collection services will be added to my account and are my responsibility.

SIGNED:____ DATE: __________________

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Patient Name ______________________________

Date ______________________

PATIENT MEDICAL HISTORY FORM

MEDICAL HISTORY

Physician ______________________________ Office Phone ________________ Date of Last Exam____________

Are you under medical treatment now? ❑ Yes ❑ No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ❑ Yes ❑ No

If yes, please explain:________________________

____

Are you taking any medication(s) including non-prescription? ❑ Yes ❑ No

If yes, please explain:________________________

____

____

____

Have you ever taken Fen-Phen/Redux? ❑ Yes ❑ No

Any history of Chemotherapy? ❑ Yes ❑ No

Any history of Bisphosphonate (Fosamax) use? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Do you use controlled substances? ❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No

Are you allergic to or have reactions to the following:

- Local anesthetics (e.g. Novocaine) ❑ Yes ❑ No
- Penicillin or Antibiotics ❑ Yes ❑ No
- Sulfa Drugs ❑ Yes ❑ No
- Barbiturates ❑ Yes ❑ No
- Sedatives ❑ Yes ❑ No
- Iodine ❑ Yes ❑ No
- Aspirin ❑ Yes ❑ No
- Any Metals (e.g. nickel, mercury, etc.) ❑ Yes ❑ No
- Latex Rubber ❑ Yes ❑ No
- Other (please list) ________________________ ❑ Yes ❑ No

____

Do you have a persistent cough or throat clearing not associated with common illness? ❑ Yes ❑ No

Are you pregnant or think you may be pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No Are you taking oral contraceptives? ❑ Yes ❑ No

High Blood Pressure	❑ Yes	❑ No	AIDS or HIV Infection	❑ Yes	❑ No	Hepatitis/Jaundice	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No	Thyroid Problem	❑ Yes	❑ No	Hay Fever/Allergies	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Fainting/Seizures	❑ Yes	❑ No	Cardiac Pacemaker	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Radiation Therapy	❑ Yes	❑ No
Low Blood Pressure	❑ Yes	❑ No	Angina / Chest Pain	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No
Epilepsy/Convulsions	❑ Yes	❑ No	Anemia	❑ Yes	❑ No	Respiratory Problems	❑ Yes	❑ No
Leukemia	❑ Yes	❑ No	Cancer	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Arthritis	❑ Yes	❑ No	Other ______________	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No	Joint Replacement/Implant	❑ Yes	❑ No	______________		

DENTAL HISTORY

Previous Dentist & Location ______________________________________ Date of Last Exam ____________

Do your gums bleed while brushing or flossing? ❑ Yes ❑ No

Are your teeth sensitive to hot or cold? ❑ Yes ❑ No

Are your teeth sensitive to sweet or sour? ❑ Yes ❑ No

Do you feel pain to any of your teeth? ❑ Yes ❑ No

Do you have any sores or lumps in or near your mouth? ❑ Yes ❑ No

Have you had any head, neck or jaw injuries? ❑ Yes ❑ No

Do you have frequent headaches? ❑ Yes ❑ No

Do you clench or grind your teeth? ❑ Yes ❑ No

Do you bite your lips or cheeks frequently? ❑ Yes ❑ No

Have you had difficult extractions in the past? ❑ Yes ❑ No

Have you had prolonged bleeding after extractions? ❑ Yes ❑ No

Have you had any orthodontic treatment? ❑ Yes ❑ No

Do you wear dentures or partials? ❑ Yes ❑ No

If yes, date of placement ________________

Have you ever received oral hygiene instructions regarding the care of your teeth and/or gums? ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____ Date ________________

Signature of patient (or patient/guardian if a minor)