Right Touch Dental Center

502-244-0007

Patient Registration

Date____________________

Patient Name ____Marital Status__________

Address____

City ____________________________ State ______ Zip ________ SS# ________________________

☐ Male ☐ Female Age_____ Birth date ____/____/______ Drive Lic. #___________________

Cell #____________________ Work #___________________ Home #_____________________

Circle the best number to confirm Cell ----- Work ---- Home **Please respond to our texts or calls.**

E-mail _____________________________ Family members seen by us ________________________

Employer and address ____

Whom may we thank for referring you?

☐ Name ___________________________________ ☐ Special Mailing ☐ 1-888-SMILE INFO
(Patient/Doctor/Specialist)

☐ Internet ☐ Newsletter ☐ Sign out Front ☐ Television ☐Other __________________

Person Responsible For Account

Name ____ Relation ________________________

Billing Address: ____ Date of Birth_____________________

Employer and address____

Work#__________________ Ext._______ SS#_________________________

Dental Insurance Primary Carrier

Insured's Name SS#

Insurance Company Phone#

Address

City State Zip

Group# ID# Birth date

Insured's Employer

****Please inform us of any secondary insurance**

Medical History

Name ____________________________ Date of Last medical physical ______________

Physician's name______________________ phone #__________________ Current physical health is ☐ good ☐ fair ☐ poor

Do you smoke or use tobacco of any form? ☐ Yes ☐ No If yes, What form? ____________ How long? ______________
Do you have any Artificial Heart Valves, Implants or Replaced Joints? ☐ Yes ☐ No WHERE? ____________________

Have you ever taken bone density medications? **Fosamax** or any bisphosphonates? ☐ Yes ☐ No
Would you like to speak to the dentist privately about drug use or medical issues? ☐ Yes ☐ No
Please list your **hospitalizations date and reason** ____
____
____
____

Have you ever had any of the following medical conditions? Please check all that apply.

- ☐ Alcohol/Drug Abuse/dependency
- ☐ Anxiety/ nervous issues/ depression
- ☐ Arthritis/Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints

- ☐ Aspirin taken daily
- ☐ Asthma
- ☐ Back issues
- ☐ Blood or bleeding issues____________________
- ☐ Cancer--type and date____________________

- ☐ Cholesterol problems
- ☐ Diabetes/ hypoglycemia
- ☐ Epilepsy/Seizures
- ☐ Eye issues
- ☐ Heart disease or heart issues

- ☐ Herpes/ fever blister /Shingles
- ☐ High blood pressure
- ☐ HIV- positive or other
- ☐ Kidney issues
- ☐ Liver issues/ Hepatitis

- ☐ Lung issues
- ☐ Premedication needed
- ☐ Sinus issues
- ☐ Snore or Sleep Apnea
- ☐ Stomach/ intestine issues

- ☐ Stroke
- ☐ Thyroid issues
- ☐ Venereal disease
- ☐ Other ______________________________

List Prescriptions, over the counter medications and herbal supplements and Conditions you are treating.

i.e. Tylenol headaches
____
____
____
____
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____

Allergies to: ☐ Anesthetics ☐ Aspirin ☐ Codeine ☐ Colored dyes ☐ **NONE**
☐ Erythromycin ☐ Latex ☐ Penicillin ☐ Tetracycline ☐ **OTHER**

Women Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Birth control pills? ☐ Yes ☐ No

Signature ______________________________ **Date** ______________

Dental History

Why have you come to the dentist today? ____

Level of pain: None-❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿-Maximum
(PLEASE CIRCLE)

Do you have any dental problems that you would like to discuss privately? ☐ Yes ☐ No

Have you ever had any **difficulties or adverse reactions** associated with previous dental treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ **Yes** ☐ **No**
Are you missing any teeth? ☐ **Yes** ☐ **No**
Do you have dental implants? ☐ **Yes** ☐ **No**

Are you interested in dental implants for missing teeth? ☐ **Yes** ☐ **No**

How many times do you: Floss________ per week? Brush _______ per day?

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No
Periodontal treatment? ☐ Yes ☐ No
"Gum treatment" or a "deep cleaning"? ☐ Yes ☐ No
A Bite guard, bite splint, or mouth guard? ☐ Yes ☐ No
A serious injury to your mouth or head? ☐ Yes ☐ No

Have you ever experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No
Muscle pain of the face? ☐ Yes ☐ No
Joint pain, ear pain, or pain on side of face? ☐ Yes ☐ No
Difficulty in opening or closing the mouth? ☐ Yes ☐ No
Headaches, neck aches, or shoulder aches? ☐ Yes ☐ No
Bad tastes or bad breath? ☐ Yes ☐ No
Recent changes in your bite? ☐ Yes ☐ No

Do you:

Clench or grind your teeth? ☐ Yes ☐ No
If Yes, when?… (circle one) Awake / Asleep
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Bite FOREIGN OBJECTS with your teeth? ☐ Yes ☐ No

Have tired jaws? ☐ Yes ☐ No

In the morning? ☐ Yes ☐ No
At the end of a stressful day? ☐ Yes ☐ No
After chewing gum? ☐ Yes ☐ No
After eating? ☐ Yes ☐ No

We are experts in cosmetic dentistry

CAN WE HELP YOU CHANGE YOUR SMILE WITH COSMETIC DENTISTRY??

ARE YOU HAPPY WITH YOUR **SMILE??** ☐ Yes ☐ No

DO YOU LIKE THE **COLOR** OR **SHADE** OF YOUR TEETH? ☐ Yes ☐ No

ARE YOU INTERESTED IN CHANGING YOUR SMILE? ☐ Yes ☐ No

IF YES, WHAT WAY______________________

____

If your spouse or responsible party contacts us regarding your treatment and/or appt times, can we discuss this information with them over the phone or in person? ☐ **Yes** ☐ **No**

Please give us any special instructions.____

It is My responsibility to inform this office of any future changes to my health and medical status. ____

Signature of patient, parent and/or guardian

*I understand that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence.

*Right Touch Dental Center is HIPAA compliant. I am providing this practice w/ my authorization to use and disclose my protected health care information for the purpose of necessary treatment, payment from a third-party payee, and health care operations as described in the Privacy Notice. RTDC is committed to meeting and exceeding the standards of Infection Control mandated by OSHA, the CDC, and the ADA. ______________________

Initials of patient

***Payment is due in full at the time of treatment**, **unless** prior arrangements have been approved. Any unpaid balances may be subject to a finance fee or late charge if payment is not received in a timely manner.

*The patient, parent and/or guardian **must give 24-hour notice**. **There is a $50 per hour fee** for each hour of scheduled appointment time missed ($100 for 2 hours). ______________________

Initials of patient

***Please respond to our calls or texts promptly.**

*I understand that I am responsible for all costs of dental treatment.

*If this office accepts my insurance, I understand that **I am responsible for payment of services rendered** and/or **responsible for paying any co-payments** and **deductibles that my insurance does not cover**.

* I herby authorize payment directly to Right Touch Dental Center of the group insurance benefits otherwise payable to me (Only if insurance applies).

***** I have read all the above statements.*****

____ _____________________

Signature **Date**

I verbally reviewed medical /dental information with patient, parent and/or guardian.

Staff____ Date ______________________________

Doctor____ Date ______________________________