ZENSMILES
5999 CUSTER ROAD, SUITE 125
FRISCO, TX 75035
214-506-1212

Patient Registration

Patient Name ____ Today's Date: ____________________

Mailing Address __________________________________ Home Phone: ______________________

City_______________ State_____ Zip: ________ Work Phone: ________________________________

Email: __________________________________ Cell Phone: __________________________________

Birth Date: ___/___/_____Age:_____ SSN: ____________________ Sex: Male Female

Marital Status: Single Married Widowed Divorced Spouses Name: _____________________

Emergency Contact: _________________ Phone Number: __________________________________

Employer: ____

How did you hear about our office? ____

Responsible Party:

Name: ____________________________ Relationship to Patient ______________________________

Mailing Address: ____________________________ Home Phone: ______________________________

City: _______________State:_____ Zip: ________ Cell Phone: ________________________________

Employer: ____

Social Security: ____________________________Birth Date: _____ /_____ /____________________

Driver's License: ____________________ Custodial Parent: Yes No Other or N/A

Relationship to Patient: ____

Dental Insurance Information:

PRIMARY INSURANCE: ______________

Employer: ____________________________

Subscriber's Name: ____________________

ID# or SS#: ___________________________

DOB: __________ Group# ____________

SECONDARY INSURANCE: ____________

Employer: ______________________________

Subscriber's Name: _____________________

ID# or SS#: ____________________________

DOB: __________ Group# ______________

Patient Signature (parent if minor):___________________________Date:___________________

HEALTH HISTORY

Name:	**SEX:** ☐ M ☐ F
Today's Date:	**DOB:**

Reason for your visit today:		
Date of last dental visit:		
Last dental cleaning: Previous Dentist:		
How often do you have dental exams?		
Do you have any dental problems now? Explain:		
How often do you brush your teeth?		
How often do you floss?		
What other dental aid do you use? (Interplak, toothpick, etc.)?		
Have you ever used or are you currently using topical fluoride?	☐ Yes	☐ No

ARE ANY OF YOUR TEETH SENSITIVE TO:		
Hot or cold?	☐ Yes	☐ No
Sweets?	☐ Yes	☐ No
Biting or Chewing?	☐ Yes	☐ No
Have you noticed any mouth odors or bad taste?	☐ Yes	☐ No
Do you frequently get old sores, blisters, or any other oral lesions?	☐ Yes	☐ No
Do your gums bleed?	☐ Yes	☐ No
Do you have swollen gums in any area of the mouth?	☐ Yes	☐ No
Have you noticed any loose teeth or change in your bite?	☐ Yes	☐ No
Does food tend to become caught in between your teeth? If so where?	☐ Yes	☐ No

DO YOU:		
Clench or grind your teeth?	☐ Yes	☐ No
Bite your lips or cheeks regularly?	☐ Yes	☐ No
Hold foreign objects with your teeth? (pencils, pipe, etc.)?	☐ Yes	☐ No
Mouth breathe while awake or asleep?	☐ Yes	☐ No
Have tired jaws, especially in the morning?	☐ Yes	☐ No
Snore or have any other sleep or breathing disorders such as **Obstuctive Sleep Apnea (OSA)?**	☐ Yes	☐ No
Smoke/chew tobacco or use tobacco products?	☐ Yes	☐ No

HAVE YOU EVER HAD:		
Orthodontic treatment?	☐ Yes	☐ No
Oral surgery?	☐ Yes	☐ No
Periodontal treatment?	☐ Yes	☐ No
Your teeth ground or the bite adjusted?	☐ Yes	☐ No
A bite plate or night guard?	☐ Yes	☐ No
A serious injury to the mouth or head?	☐ Yes	☐ No

HAVE YOU EXPERIENCED:		
Clicking or popping of the jaw?	☐ Yes	☐ No
Pain? (joint, ear, side of face)	☐ Yes	☐ No
Difficulty in opening or closing the mouth?	☐ Yes	☐ No
Headaches, neck aches or shoulder aches?	☐ Yes	☐ No

DENTAL HISTORY:

Question	Yes	No
Do you feel nervous about having dental treatment?	☐ Yes	☐ No
Have you ever had an upsetting dental experience?	☐ Yes	☐ No
Have you ever been told to take **pre-medication prior to dental treatment?**	☐ Yes	☐ No
Would you like to replace your silver fillings?	☐ Yes	☐ No
Are you satisfied with your teeth's appearance?		

MEDICAL HISTORY:

Question	Yes	No
Physician's Name: Phone number:		
Have you taken any prescribed medications during the last two years?	☐ Yes	☐ No
If yes, please list name and dosage:		
Are you currently taking any medications, pills, or herbal remedies, including regular dosages of aspirin?	☐ Yes	☐ No
If yes, please list name and dosage:		
Have you ever taken **bone loss prevention drugs** such as **Fosamax, Actonel, Boniva or other bisphosphonates?**	☐ Yes	☐ No
If yes, please list name and dosage		
Are you aware of having an **allergic (or adverse) reaction** to any substance or medication	☐ Yes	☐ No
If yes, please specify:		
Have you been a patient in the hospital during the past five years?	☐ Yes	☐ No
Do you currently or have **ever taken any Illicit drugs or abused prescription medications?**	☐ Yes	☐ No
Do you have or have you had any disease, condition, or problem not listed?	☐ Yes	☐ No
WOMEN: **Are you pregnant or think you could be?**	☐ Yes	☐ No
Do you use birth control pills?	☐ Yes	☐ No

HAVE YOU EVER HAD OR DO YOU HAVE:

Condition	Yes	No
Ulcers	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Hay Fever/Allergy/Hives	☐ Yes	☐ No
Latex Sensitivity	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Tumors	☐ Yes	☐ No

Condition	Yes	No
Heart (Surgery, Disease, Attack)	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
High/low Blood Pressure	☐ Yes	☐ No
Mitral Value Prolapse	☐ Yes	☐ No
Artificial Heart Value/Pacemaker	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No

Condition	Yes	No
Hepatitis A B C (circle)	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
AIDS/HIV Positive	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No
Bruises Easily	☐ Yes	☐ No
Liver Disease/Yellow Jaundice	☐ Yes	☐ No
Neurological Disorders	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No
Fainting or Dizzy Spells	☐ Yes	☐ No
Nervous/Anxious	☐ Yes	☐ No
Psychiatric/Psychological Care	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

I understand the above information is necessary to provide me with dental care and/or sedation in a safe and efficient manner. **I have answered all questions truthfully and to the best of my knowledge.** Should further information be needed, you have my permission to ask the respective health care provider or agency, who may releases such information to you.

I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature: ______________________________ Date: ______________

Cancellations

An appointment together is a bond of trust that we will be here to serve you and you will be present for your scheduled treatment. We do not overbook our schedule so that you may receive individual care in a timely manner. We have developed the following policy in an effort to provide excellent dental care to all of our valued patients.

Please give our office 48 hours' notice if you need to reschedule your appointment. Appointments rescheduled within that period will incur a charge of $50 per hour of schedule time. By chance, if a scheduled appointment is missed, the same charge will incur. Your insurance company will not cover cancellation charges.

Thank you for your commitment to our practice and we promise to ensure excellent and timely care to you, your family and friends.

Patient Name (Print): ______________________________

Relationship to Patient: ______________________________

Patient Signature/Guardian: ______________________________

Date: ______________________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ❑Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ❑Obtain payment from third-party payers for my health care services
- ❑Conduct normal health care operations such as quality assessment and improvement activities

I have been informed by my dental provider's Notice of Privacy Practices, that contain a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ________________________________ Date: ________________________

Signature: ____________________________________

Relationship to Patient: ________________________

Dependent family members also covered by this acknowledgement:
____

____

For Office Use Only:

We were unable to obtain the patients written acknowledgement of our Notice of Privacy Practices due to the following reason:

❑The patient refused to sign
❑Communication barriers
❑Other