PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL PATIENT REGISTRATION INFORMATION FORMS USING YOUR KEYBOARD AND MOUSE. PLEASE PRINT, SIGN AND THEN MAIL, FAX OR BRING THE FORMS WITH YOU TO YOUR NEXT APPOINTMENT. OUR MAILING ADDRESS IS MICHAEL MOATS, DDS, 135 NORTH ARLINGTON ROAD, SUITE 150, BUFFALO GROVE, IL 60089. OUR FAX NUMBER IS 847.279.1450.

IF THIS **APPOINTMENT IS FOR YOU START HERE**

1

DATE			
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE ☐	FEMALE ☐
MARRIED ☐	SINGLE ☐	DIVORCED ☐	WIDOWED ☐
SOCIAL SECURITY NO.			

IF THIS **APPOINTMENT IS** FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE ☐	FEMALE ☐
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2

DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

3

GETTING TO KNOW YOU		
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

4

ACCOUNT INFORMATION		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ______________________________ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 /2% late charge (I 8% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature ______________________________ Date ______________ Witness ____________________

Parent/Responsible Party's Signature ________________________________ Relationship to Patient ____________

Patient Name	**DENTAL HISTORY**
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? ____________________

____

Date of Last Dental Visit __________ **Last Dental Cleaning** __________ **Last Full Mouth X-rays** __________

What was done at your last dental visit? ____________________

____

Previous Dentist's Name ____________________

Address ____________________ State ________ Zip ________

Telephone ____________________

How often do you have dental examinations? ____________________

How often do you brush your teeth? __________ How often do you floss? __________

What other dental aids do you use? (Interplak, toothpick, etc.) ____________________

Do you have any dental problems now? ❒ YES ❒ NO

If yes, please describe: ____________________

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 tastes? ❒ YES ❒ NO

Do you frequently get cold sores, blisters or any other oral lesions? ❒ YES ❒ NO

Do your gums bleed or hurt? ❒ YES ❒ NO

Have your parents experienced gum disease or tooth loss? ❒ 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? ❒ YES ❒ NO

If yes, where? ____________________

Do you:

- Clench or grind your teeth while awake or asleep? ❒ YES ❒ NO
- Bite your lips or cheeks regularly? ❒ YES ❒ NO
- Hold foreign objects with your teeth? ❒ YES ❒ NO
- (pencils, pipe, pins, nails, fingernails) ❒ YES ❒ NO
- Mouth breathe while &wake or asleep? ❒ YES ❒ NO
- Have tired jaws, especially in the morning? ❒ YES ❒ NO
- Smoke/chew tobacco? ❒ 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 mouth guard? ❒ YES ❒ NO
- A serious injury to the mouth or head? ❒ YES ❒ NO

If so, please describe, including cause

____

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
- Difficulty in chewing on either side of the mouth? ❒ YES ❒ NO
- Headaches, neckaches or shoulder aches? ❒ YES ❒ NO
- Sore muscles (neck, shoulders)? ❒ YES ❒ NO

Are you satisfied with your teeth's appearance? ❒ YES ❒ NO

Would you like to keep all of your teeth all of your life? ❒ YES ❒ NO

Do you feel nervous about having dental treatment? ❒ YES ❒ NO

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience? ❒ YES ❒ NO

If yes, please describe

____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe ____________________

____

____

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Patient Name	
Patient Account No.	Medical Alert

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? .... ❒ YES ❒ NO
   If yes, for what? ____________________
   Physician's Name ____________________ Phone ____________________
   Address ____________________ City ____________________ State __________ Zip __________
2. Have you taken any medication or drugs during the past two years? .... ❒ YES ❒ NO
3. Are you taking any medication, drugs or pills now? .... ❒ YES ❒ NO
   If yes, please list name and dosage ____________________
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? .... ❒ YES ❒ NO
   If yes, please list: ____________________
5. Have you been a patient in the hospital during the past five years? .... ❒ YES ❒ NO
6. Indicate which of the following you have had, or have at present. Check if using your keyboard or a pen, "yes" or "no" to each item.

Condition	YES	NO	Condition	YES	NO	Condition	YES	NO
Heart (Surgery, Disease, Attack)	❒ YES	❒ NO	Ulcers	❒ YES	❒ NO	Hepatitis A (infectious) B (serum)	❒ YES	❒ NO
Chest Pain	❒ YES	❒ NO	Diabetes	❒ YES	❒ NO	Venereal Disease	❒ YES	❒ NO
Congenital Heart Disease	❒ YES	❒ NO	Thyroid Problems	❒ YES	❒ NO	A.I.D.S.	❒ YES	❒ NO
Heart Murmur	❒ YES	❒ NO	Glaucoma	❒ YES	❒ NO	H.I.V. Positive	❒ YES	❒ NO
High Blood Pressure	❒ YES	❒ NO	Contact lenses	❒ YES	❒ NO	Cold Sores/Fever Blisters	❒ YES	❒ NO
Mitral Valve Prolapse	❒ YES	❒ NO	Emphysema	❒ YES	❒ NO	Blood Transfusion	❒ YES	❒ NO
Artificial Heart Valve	❒ YES	❒ NO	Chronic Cough	❒ YES	❒ NO	Hemophilia	❒ YES	❒ NO
Heart Pacemaker	❒ YES	❒ NO	Tuberculosis	❒ YES	❒ NO	Sickle Cell Disease	❒ YES	❒ NO
Rheumatic Fever	❒ YES	❒ NO	Asthma	❒ YES	❒ NO	Bruise Easily	❒ YES	❒ NO
Arthritis/Rheumatism	❒ YES	❒ NO	Hay Fever	❒ YES	❒ NO	Liver Disease	❒ YES	❒ NO
Cortisone Medicine	❒ YES	❒ NO	Latex Sensitivity	❒ YES	❒ NO	Yellow Jaundice	❒ YES	❒ NO
Swollen Ankles	❒ YES	❒ NO	Allergies or Hives	❒ YES	❒ NO	Neurological Disorders	❒ YES	❒ NO
Stroke	❒ YES	❒ NO	Sinus Trouble	❒ YES	❒ NO	Epilepsy or Seizures	❒ YES	❒ NO
Diet (Special/ Restricted)	❒ YES	❒ NO	Radiation Therapy	❒ YES	❒ NO	Fainting or Dizzy Spells	❒ YES	❒ NO
Artificial Joints (hip, knee, etc.)	❒ YES	❒ NO	Chemotherapy.	❒ YES	❒ NO	Nervous/Anxious	❒ YES	❒ NO
Kidney Trouble	❒ YES	❒ NO	Tumors	❒ YES	❒ NO	Psychiatric/Psychological Care	❒ YES	❒ NO

7. Do you use more than two pillows to sleep? .... ❒ YES ❒ NO
8. Have you lost or gained more than 1 0 pounds in the past year? .... ❒ YES ❒ NO
9. Do you have or have you had any disease, condition, or problem not listed? .... ❒ YES ❒ NO
   If yes, please list: ____________________
10. Women. Are you: **Pregnant?** ❒ YES ___ Months ❒ NO Nursing? ❒ YES ❒ NO **Taking birth control pills?** ❒ YES ❒ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions 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 release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature ____________________ Date __________

History Review

Dentist Signature ____________________ Date __________

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