

**Chris Furlan, DMD**

                                                                                      \_                                                           /             /

First Last M Today’s Date

                                                 \_\_\_\_                                            \_\_                         /         /             \_\_\_\_\_

Preferred Name Suffix Marital Status Date of Birth Age

                   \_                                                                                               \_                                       -             -

Address Social Security #

City, State, Zip Apt. Occupation

E-Mail Home Phone #

Preferred appointment reminder: *Home, cell, work, text, or e-mail* Cell Phone #

Whom may we thank for referring you? *Friend, Internet, etc.*  Work Phone #

**EMERGENCY CONTACT**

                                                                                         \_                       \_\_\_\_\_\_\_\_

Emergency Contact Name and relationship Emergency Contact Phone #

**MEDICAL HISTORY**

                                                                                     \_\_                                                \_\_\_\_\_\_\_

Physician’s Name Physician’s Phone #

                                                                                         \_\_                                                         \_\_\_\_\_\_\_

Physician’s Address Date & Reason for your last visit

                                                                                              \_\_                                  \_\_\_\_\_\_\_

Pharmacy Name & Address Pharmacy Phone #

Please list any allergies or reactions to medications (*including local anesthesia “Novocaine*”)

Please list any major operations and dates

                    \_

Please describe any serious injury to your head and neck

                    \_

Please list any other known medical problems

                    \_

Please list any other known medical problems

                                                                        \_\_\_                             \_                \_\_\_\_\_\_\_\_\_\_\_\_

(*For Women*) Are you Pregnant? (or possibly?) Nursing? Do you smoke? If yes, how many & how long?

|  |  |  |
| --- | --- | --- |
| **CURRENT MEDICATIONS** | **REASON** | **DOSE** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

***PLEASE* CHECK ALL THAT APPLY:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Maybe** | **Comment** |
| Heart Murmur |  |  |  |  |
| Mitral Valve Prolapse |  |  |  |  |
| Rheumatic or Scarlet Fever |  |  |  |  |
| Rheumatic Heart Disease |  |  |  |  |
| Congenital Heart Disease |  |  |  |  |
| Heart Attack |  |  |  |  |
| Angina (“chest pain”) |  |  |  |  |
| Irregular Heartbeat |  |  |  |  |
| Cardiac Surgery |  |  |  |  |
| Pacemaker |  |  |  |  |
| Heart Valve Replacement |  |  |  |  |
| High or Low Blood Pressure |  |  |  |  |
|  |  |  |  |  |
| Excessive Bleeding / Bruising |  |  |  |  |
| Hemophilia |  |  |  |  |
|  |  |  |  |  |
| Stroke |  |  |  |  |
| Convulsions or Fainting |  |  |  |  |
|  |  |  |  |  |
| Thyroid Problems |  |  |  |  |
| Kidney Problems / Dialysis |  |  |  |  |
| Hepatitis or Liver Disease |  |  |  |  |
|  |  |  |  |  |
| Breathing Problems |  |  |  |  |
| Asthma |  |  |  |  |
| Emphysema |  |  |  |  |
| Hay Fever / Seasonal Allergies |  |  |  |  |
| Tuberculosis |  |  |  |  |
| Sinus Problems |  |  |  |  |
|  |  |  |  |  |
| Stomach Problems / Ulcers |  |  |  |  |
| Acid Reflux / GERD |  |  |  |  |
| Intestinal Disease |  |  |  |  |
|  |  |  |  |  |
| Diabetes |  |  |  |  |
|  |  |  |  |  |
| Venereal Disease |  |  |  |  |
| AIDS / HIV + |  |  |  |  |
|  |  |  |  |  |
| Tumors / Growths |  |  |  |  |
| Cancer (where and when?) |  |  |  |  |
| Chemotherapy |  |  |  |  |
| Radiation Therapy |  |  |  |  |
|  |  |  |  |  |
| Arthritis / Rheumatism |  |  |  |  |
| Sjogren’s Disease |  |  |  |  |
|  |  |  |  |  |
| Allergies to Medications |  |  |  |  |
| Headaches |  |  |  |  |
| Drug / Alcohol Addiction |  |  |  |  |
| Eating Disorder |  |  |  |  |
| Sleep Apnea |  |  |  |  |
| CPAP |  |  |  |  |
|  |  |  |  |  |
| Artificial Joint Replacement |  |  |  |  |
| Antibiotic Premedication |  |  |  |  |

**DENTAL HISTORY**

**Reason for your visit here today:**

                                                                                   \_\_\_\_\_

                                                                                   \_\_\_\_\_

                                                                       \_\_\_\_\_\_\_\_\_\_\_

Date & Reason of your last dental appointment

                                                                       \_\_\_\_\_\_\_\_\_\_\_

Treatment given at your last dental appointment

Name & Location of your previous dentist Date and amount of your last dental X-Rays

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Y** | **N** | **COMMENT** |
| Do you get **Cold Cores**? How often? |  |  |  |
| Do you get **Canker Sores**? How often? |  |  |  |
|  |  |  |  |
| Have you ever had an **allergic** reaction from a dental procedure? |  |  |  |
| Have you ever had abnormal **bleeding** after a dental procedure? |  |  |  |
| Have you ever felt **anxious** before / during a dental procedure? |  |  |  |
|  |  |  |  |
| Are any of your teeth sensitive to **hot / cold?** |  |  |  |
| Are any of your teeth sensitive to **sweets**? |  |  |  |
| Are you having pain when **biting / chewing**? |  |  |  |
|  |  |  |  |
| Do any of your teeth feel **loose** to you? |  |  |  |
| Do your **gums bleed** when you brush your teeth? |  |  |  |
| Do you / have you been told you have **Periodontal disease**? |  |  |  |
| Do you / have you been told you have **receding gums**? |  |  |  |
|  |  |  |  |
| Do you / have you been told you **clench / grind** your teeth? |  |  |  |
| Do you have a **Night Guard**? Do you use it? |  |  |  |
|  |  |  |  |
| Are you / have you been told that you are a “**mouth breather”?** |  |  |  |
| Do you ever experience “**dry mouth**” (not enough saliva) |  |  |  |
| Do you wear or have a **denture or partial**? (removable teeth) |  |  |  |
| Do you / have you ever had **orthodontics or Invisalign**? When? |  |  |  |
| Were you given a **Retainer**? Do you use it? |  |  |  |
|  |  |  |  |
| Do you / have you ever had **dental implants**? |  |  |  |
| Have you had **oral surgery** / wisdom teeth removed? |  |  |  |

**RELEASES AND CONSENTS**

**WARNING**: Anesthetics and other medications that may be necessary in your dental treatment may interact with prescriptions, over-the-counter drugs and medications, and illicit drugs. These interactions may be serious and fatal.

You must inform the doctor of all drugs and medications you are now taking, or have ever taken. You must also disclose if you are a recovering alcoholic or drug user. All information will be held in the strictest confidence and will not be disclosed without your prior approval.

**LOCAL ANESTHESIA**: there are several rare but possible risks or complications associated with local anesthesia (such as Novocaine) including but not limited to bruising, swelling, infection or discoloration at the injection site; temporary or permanent numbness and/or tingling of the lip, tongue, chin, gums, palate, cheek, pharynx or other injected tissue; spasm of the facial muscles; pain to the head, ears and/or neck; nausea; vomiting; irregular or accelerated heartbeat; cardiac arrest and/or death.

**FOR FEMALE PATIENTS:** Some antibiotics used in dentistry may decrease the effectiveness of birth control pills.

**CONSENT:** I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I consent, knowingly and voluntarily to the administration of local anesthesia with the associated risks as outlined above.

I am aware that the practice of dental medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of proposed treatments and/or anesthesia.

To the best of my knowledge, the information that I have furnished in the foregoing patient registration is complete and accurate. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors and/or other health practitioners.

**I hereby certify that I have read this patient registration that I have answered all questions to the best of my knowledge, and I agree to the terms expressed within.**

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:             /                 /

**If other than patient, indicate relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FINANCIAL AGREEMENT**

***IF YOU DO NOT HAVE DENTAL INSURANCE***

Payment is expected at the time of treatment unless other specific arrangements are made beforehand. For your convenience, we accept VISA and Mastercard. Payments more than thirty days past due will be assessed a finance charge of 1.25% per month. We try to keep our fees low by avoiding unnecessary finance and collection expenses. Thank you for your cooperation.

***IF YOU HAVE DENTAL INSURANCE:***

We will be happy to submit all necessary forms to your carrier. However, we request that you pay your estimated portion as services are rendered. Please understand that you are responsible for any portion of your fee not covered by your insurance.

***DENTAL INSURANCE INFORMATION:***

If you have insurance, the following release will allow for your insurance company to pay your benefits directly to this office:

I hereby authorize payment directly to this office of benefits payable to me for dental services rendered. I understand that I am financially responsible for any charges not covered by this authorization.

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:        /        /

**INSURANCE POLICY**

**Please complete the following section or provide us with a completed insurance form from your policy:**

**Relationship** of patient to employee (check one): Self\_\_\_\_\_ Spouse\_\_\_\_\_ Child\_\_\_\_\_

Insurance Company Insurance Company Address

                                                                                                                                                                               \_\_

Employee’s Name

                /                 /                                           -               -

Employee’s Date of Birth Employee’s Social Sec. #

Employee's Address

Employer's

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #                                I.D.#

Employer's Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient a **full-time student**?          School:                      \_     \_                  City

***( PLEASE LEAVE THIS PAGE BLANK )***

**HOME CARE RECOMMENDATIONS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Initial Visit(date: ) |  |  |  |  |
| **BRUSH** |  |  |  |  |  |
|  BRUSH |  |  |  |  |  |
|  PROXABRUSH |  |  |  |  |  |
|  ELECTRIC BRUSH |  |  |  |  |  |
|  DENTURE BRUSH |  |  |  |  |  |
| **TOOTHPASTE** |  |  |  |  |  |
|  PASTE  |  |  |  |  |  |
|  SENSITIVITY |  |  |  |  |  |
|  PREVIDENT (high Fluoride) |  |  |  |  |  |
| **FLOSS** |  |  |  |  |  |
|  FLOSS |  |  |  |  |  |
|  SUPERFLOSS |  |  |  |  |  |
|  THREADER |  |  |  |  |  |
|  HOLDER |  |  |  |  |  |
| **RINSE** |  |  |  |  |  |
|  FLUORIDE |  |  |  |  |  |
|  LISTERINE |  |  |  |  |  |
|  PLAX |  |  |  |  |  |
|  PERIDEX |  |  |  |  |  |
| OTHER |  |  |  |  |  |
| **ADJUNCTS** |  |  |  |  |  |
| WATER PIK |  |  |  |  |  |
| PLACKERS |  |  |  |  |  |
|  RUBBER TIP |  |  |  |  |  |
|  TOOTHPICK |  |  |  |  |  |
|  STIMUDENTS |  |  |  |  |  |
| OTHER  |  |  |  |  |  |
|  OTHER |  |  |  |  |  |

 **R** - RECOMMENDED

 **U** - PATIENT CURRENTLY USING

 **D** - ADVISED TO DISCONTINUE

**RN** - RECOMMENDED BUT NOT USING