# PATIENT REGISTRATION

**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION**

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

| DENTAL INSURANCE 2 | |
|---|---|
| **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. | |

| ACCOUNT INFORMATION 4 | | |
|---|---|---|
| **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. | |

| GETTING TO KNOW YOU 3 |
|---|
| **IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?** |
| NAME: |
| RELATIONSHIP: |
| **YOU WERE REFERRED TO US BY** |
| NAME: |
| **PERSON TO CONTACT FOR EMERGENCY** |
| NAME: |
| CELL NUMBER |
| HOME NUMBER |
| ADDRESS |
| CITY STATE ZIP |

| 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 _____ Telephone _____

Address _____ State _____ Zip _____

**How often do you have dental examinations?** _____

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

Have you ever used or are currently using topical fluoride? Yes No

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? (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 sleeping disorders? | Yes | No |
| Smoke/chew tobacco or use other 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 mouth guard? | Yes | No |
| A serious injury to the mouth or head? | Yes | No |

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 replace your silver fillings? | 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

Please describe _____

Have you ever had an upsetting dental experience? Yes No

Please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

**Is there anything else about having dental treatment that you would like us to know?** Yes No

If yes, please describe _____

_____

(Please complete other side)

| Patient Name | MEDICAL HISTORY |
|---|---|
| Patient Account No. | Medical Alert |

1. Physician's Name _____ Phone (  ) _____
   Have you had any medical care within the past two years? ..... Yes No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
   If yes, please list name and dosage _____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No
   If yes, please list name and dosage _____
4. 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 _____
5. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... Yes No
   If yes, please specify _____
6. Have you been a patient in the hospital during the past five years? ..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) | Yes | No | Ulcers | Yes | No | Hepatitis A B C (circle) | 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./H.I.V. Positive | Yes | No |
| Heart Murmur | Yes | No | Glaucoma | Yes | No | Cold Sores/Fever Blisters | Yes | No |
| High/Low Blood Pressure | Yes | No | Contact lenses | Yes | No | Blood Transfusion | Yes | No |
| Mitral Valve Prolapse | Yes | No | Emphysema | Yes | No | Hemophilia | Yes | No |
| Artificial Heart Valve/Pacemaker | Yes | No | Chronic Cough | Yes | No | Sickle Cell Disease | Yes | No |
| Rheumatic Fever | Yes | No | Tuberculosis | Yes | No | Bruise Easily | Yes | No |
| Arthritis/Rheumatism | Yes | No | Asthma | Yes | No | Liver Disease/Yellow Jaundice | Yes | No |
| Cortisone Medicine | Yes | No | Hay Fever/Allergy/Hives | Yes | No | Neurological Disorders | Yes | No |
| Swollen Ankles | Yes | No | Latex Sensitivity | Yes | No | Epilepsy or Seizures | Yes | No |
| Stroke | Yes | No | Sinus Trouble | Yes | No | Fainting or Dizzy Spells | Yes | No |
| Diet (Special/Restricted) | Yes | No | Radiation Therapy | Yes | No | Nervous/Anxious | Yes | No |
| Artificial Joints (hip, knee, etc.) | Yes | No | Chemotherapy | Yes | No | Psychiatric/Psychological Care | Yes | No |
| Kidney Trouble | Yes | No | Tumors | Yes | No | Cancer | Yes | No |

8. Have you lost or gained more than 10 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 or think you could be pregnant? Yes _____Months No **Nursing?** Yes No
11. Do you use birth control prescriptions? ..... 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 _____

# 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 (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

6 Cell Phone: ❑ I consent to the dental practice using my cell phone number to (choose one or both) ❑ call or ❑ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) _____

Patient's Signature_____ Date _____ Witness_____

Parent/Responsible Party's Signature _____ Relationship to Patient_____

**MARK W LANGBERG DDS, MAGD, PC**
**26206 W. 12 MILE RD, STE 303**
**SOUTHFIELD, MI 48034**
(248)356-8790

**We are grateful you have chosen us. Please help us learn more about our web presence.**

How did you hear about us?_____

If you found us on the internet, how did you search?_____

Google_____ Yahoo_____ Bing_____ Angie's List_____ Other_____

What specific search words did you use?_____

What about our website attracted you?_____

## Acknowledgement of Receipt of this Practices Privacy Notice

I acknowledge that I have been given the choice of reviewing the Notice of Privacy Practices of this office. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that the Notice of Privacy Practice is kept in each treatment room of the office where I can review it if desired.

_____ _____

Patient or Patient Representative or Parent
(If patient representative signs above, please include relationship to patient)

Date

**The patient presented for treatment on this date and was provided with the Practice Privacy Notice. A good faith effort was made to obtain written acknowledgement of receipt. A written acknowledgement was not obtained because:**

_____ Patient refused to sign, with the reason_____

_____ Patient is unable to sign due to_____

_____ There was a medical emergency preventing timely signature, and an attempt will be made to obtain acknowledgement later.

_____ Other_____

Employee Signature_____ Date_____