



Patient Registration Information (CONFIDENTIAL)

Name: _____
First Middle Last Preferred Name

Address: _____
City State Zip code Social Security #

Date of birth: _____ Age: _____ Email Address: _____

Home Phone: _____ Cell: _____ Work: _____

**Mark Preferred Number

Referred by: _____

Responsible Party Information (If under age 18 only)

Name: _____
First Middle Last Date of Birth

Address: _____
City State Zip code Social Security #

Home Phone: _____ Cell: _____ Work: _____

**Mark Preferred Number

Place of Employment: _____ Relationship to Patient: _____

Insurance Information

Name of Insured: _____
First Middle Last Date of birth

Address of Insured: _____
City State Zip code Social Security #

Phone: _____ Place of Employment: _____ Relationship to Patient: _____

Insurance Company: _____ Phone: _____ Member ID: _____

If you have dual insurance

Name of insured: _____
First Middle Last Date of birth

Address of Insured: _____
City State Zip code Social Security #

Phone: _____ Place of Employment: _____ Relationship to Patient: _____

Insurance Company: _____ Phone: _____ Member ID: _____

Emergency Contact Information (outside of immediate household)

Name: _____ Home Phone: _____ Cell Phone: _____

Financial Responsibility

We will gladly bill your insurance for you and estimate your share at the time of treatment. **Payment for your estimated portion is due at the time of service.** For your convenience we accept the following methods of payment (please check the option your prefer):

Cash or Checks Mastercard or Visa Monthly payments (CARE CREDIT approval required)

I acknowledge that I am financially responsible for all charges and balances over 30 days may incur 1.5% monthly finance charge. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I understand that chronically missed and/or canceled appointments may result in a **\$75 fee**. I authorize **Hidden Springs Family Dentistry** to bill my insurance company as well as release any information needed to do so and assign benefits to **Jed Volvovic, DMD**.

Signature: _____ Date: _____

Patient Dental History (CONFIDENTIAL)

Primary reason for your visit today? _____



HIDDEN SPRINGS
FAMILY DENTISTRY
Dr. Jed Volvovic, DMD

When was your last dental visit? _____ Name of previous dentist: _____

Have your previous dental experiences been favorable? _____ If not, please explain: _____

Reason for changing dentists: _____

Have you experienced any of the following:	Yes	No		Yes	No
Sensitivity to hot or cold.....	<input type="checkbox"/>	<input type="checkbox"/>	Root canal treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to sweets or sour.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to pressure/biting.....	<input type="checkbox"/>	<input type="checkbox"/>	Habitual grinding or clenching of teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums while brushing/flossing.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaw joint pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequently bite cheeks/lips.....	<input type="checkbox"/>	<input type="checkbox"/>	Clicking or popping of jaw.....	<input type="checkbox"/>	<input type="checkbox"/>
Sores or lumps in or around your mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	Pain in ear or side of face.....	<input type="checkbox"/>	<input type="checkbox"/>
Gum recession.....	<input type="checkbox"/>	<input type="checkbox"/>	Crooked teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal (gum) treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	Does food catch between your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Cracked or broken teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficult extractions.....	<input type="checkbox"/>	<input type="checkbox"/>	Discolored teeth.....	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

This information will help us in preventing serious medical complications. Please let us know if there is anything not listed, that you feel we should know about, in regards to your medical/dental health.

Name of Physician: _____ Date of last physical: _____

Are you under medical treatment now? _____ If yes, describe: _____

Have you been hospitalized or had a serious illness in the last 3 years? _____ Explain: _____

Do you smoke or use smokeless tobacco? _____ If yes, how often? _____ How many years? _____

Please list any medications, including non-prescription medicine:			Have you had, at any time, any of the following:	Y	N		Y	N
_____			Aids/HIV.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Angina/Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Artificial joint/Implant...	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure..	<input type="checkbox"/>	<input type="checkbox"/>
_____			Asthma/resp. problems...	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Bleeding problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergies or reactions to:	Y	N	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Codine.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care.....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea.....	<input type="checkbox"/>	<input type="checkbox"/>
Latex.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach issues/ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Please list: _____			Glaucoma/Cataracts.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Use of CPAP.....	<input type="checkbox"/>	<input type="checkbox"/>
Women: Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

I have read and understand the above information and have answered truthfully to the best of my knowledge. I understand that providing incorrect information may be dangerous to my medical/dental health.

Signature: _____ **Date:** _____