C. Roger Macias, Jr. DDS
Aesthetic and Restorative Dentistry

PATIENT REGISTRATION (please print firmly and clearly)

ABOUT YOU

Today's Date:_________________

Name ____ SS# ____
(last) (first)

I prefer to be called_______________________________________

Home Phone (___) ____________________________________ Cell Phone (___)________________________________

Address ____

City ____ State ___________ Zip Code ______________________

Birthdate____ Male ______ Female

Single ______ Married ______ Widowed ______ Separated ______ Divorced ______ Significant Other ______

Employer____

Occupation ____

Employer's Address ____________________________________ Phone______________________________________

How long there? ____

When and where are the best times to reach you?____

Other family member seen by us: ____

Whom may we thank for referring you to us?____

Email:____

Emergency Contact ____________________________________ Relationship______________ Phone______________

Emergency Contact ____________________________________ Relationship______________ Phone______________

Pharmacy Name and Phone ____

ABOUT YOUR SPOUSE

Name ____ SS# ____

Employer____

Home Number (___)____________________________________ Work Number (___) _______________ Ext _________

Birthdate____ Drivers License # ____________________________

Person Responsible for Account ____

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Billing Address ______________________________

Relation ______________________________

DENTAL INSURANCE INFORMATION, PRIMARY DENTAL INSURANCE

Insurance Company ______________________________

Insurance Company Address ______________________________

Insurance Compnay Phone ______________________________

Group # (Plan, Local or Policy #) ______________________________

Insured SS# ______________________________

Insured's Name ______________________________

Insured's Birthdate ______________________________

Insured's Employer ______________________________

DENTAL INSURANCE INFORMATION, SECONDARY DENTAL INSURANCE

Insurance Company ______________________________

Insurance Company Address ______________________________

Insurance Compnay Phone ______________________________

Group # (Plan, Local or Policy #) ______________________________

Insured SS# ______________________________

Insured's Name ______________________________

Insured's Birthdate ______________________________

Insured's Employer ______________________________

I understand responsibility for payment of dental services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered unless financial arrangements have been made.

I hereby authorize payment of insurance benefits directly to Dr. Macias.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts by signing this agreement, I agree to be responsible for payment of services not paid in whole or in part by my dental care payor.

Patient's or Guardian's Signature ______________________________ Date __________

DENTAL HISTORY (please print firmly and clearly)

Reason for seeing the Doctor today ____________________

Date of last dental visit____________ Last dental cleaning ____________ Last full mouth x-rays ____________

What was done at your last dental visit? ____________________

Your previous Dentist's name ____________________ Address ____________________

City ____________________ State ________ Zip Code ______ Phone ________

How often do you see a dentist? ________ How often to you brush? ________ How often do you floss? ________

Do you use dental aids? (Toothpick, interplak, etc.) ____________________

Do you have dental problems now? ❏ Yes ❏ No If yes, 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 hurt or bleed?	❏ 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 become caught 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 objects with your teeth? (pencils, pins, nails, etc.)	❏ Yes	❏ No
Mouth break while asleep or awake?	❏ 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 plateor mouth guard?	❏ Yes	❏ No
A serious injury to the head or mouth?	❏ Yes	❏ No

If yes, describe, including the cause ____________________

HAVE YOU EVER EXPERIENCED:

Clicking or popping of the jaw?	❏ Yes	❏ No
Pain? (joint, ear, side of face)	❏ Yes	❏ No
Difficulty opening/closing the mouth?	❏ Yes	❏ No
Difficulty chewing on either side of your mouth?	❏ Yes	❏ No
Head, neck or shoulder arches?	❏ Yes	❏ No
Are you satisfied with the way your teeth look?	❏ Yes	❏ No
Would you like to keep all of your teeth al of your life?	❏ Yes	❏ No
Do you feel nervous about having dental treatment?	❏ Yes	❏ No

If yes, what is your biggest concern? ____________________

Have you ever had an upsetting dental experience?

If yes, please describe ____________________

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

____

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MEDICAL HISTORY (please print firmly and clearly)

Have you been under the care of a medical doctor during the past two years? ❑ Yes ❑ No

If yes, for what reason? ______________________________

Physician's Name ______________________ Phone ______________________

Address ______________________ City __________ State __________ Zip __________

Have you taken any medication or drugs during the past two years? ❑ Yes ❑ No

Are you currently taking any medication, drugs or pills? ❑ Yes ❑ No

If yes, list name and dosage ______________________________

Are you aware of having an allergic or adverse reaction to any medication or substance? ❑ Yes ❑ No

If yes, describe ______________________________

Have you been a patient in the hospital during the past five years? ❑ Yes ❑ No

Name and phone number of preferred pharmacy ______________________________

PLEASE INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD, OR HAVE AT PRESENT. CIRCLE Y FOR *YES*, N FOR *NO*.

Condition		Condition		Condition	
Heart Attack, Surgery or Disease	Y N	Ulcers	Y N	Hepatitis A (infectious) B (serum)	Y N
Chest Pain	Y N	Diabetes	Y N	Venereal Disease	Y N
Congenital Heart Disease	Y N	Thyroid Problems	Y N	A.I.D.S.	Y N
Heart Murmur	Y N	Glaucoma	Y N	H.I.V. Positive	Y N
High Blood Pressure	Y N	Contact Lenses	Y N	Cold Sores/Fever Blisters	Y N
Mitral Valve Prolapse	Y N	Emphysema	Y N	Blood Transfusion	Y N
Artificial Heart Valve	Y N	Chronic Cough	Y N	Hemophilia	Y N
Heart Pacemaker	Y N	Tuberculosis	Y N	Sickle Cell Disease	Y N
Rheumatic Fever	Y N	Asthma	Y N	Bruise Easily	Y N
Arthritis, Rheumatism	Y N	Hay Fever	Y N	Liver Disease	Y N
Cortisone Medicine	Y N	Latex Sensitivity	Y N	Yellow Jaundice	Y N
Swollen Ankles	Y N	Allergies or Hives	Y N	Neurological Disorders	Y N
Stroke	Y N	Sinus Trouble	Y N	Epilepsy or Seizures	Y N
Diet (Special/Restricted)	Y N	Radiation Therapy	Y N	Fainting or Dizzy Spells	Y N
Artificial Joints (Hip, Knee, etc)	Y N	Chemotherapy	Y N	Nervous/Anxious	Y N
Kidney Trouble	Y N	Tumors	Y N	Psychiatric/Psychological Care	Y N

Do you have or have you had any disease, condition or problem not listed above? ❑ Yes ❑ No

If yes, describe ______________________________

Do you use more than two pillows to sleep? ❑ Yes ❑ No

Have you lost or gained more than 10 pounds in the past year? ❑ Yes ❑ No

Women: Are you pregnant? ❑ Yes ______ ❑ No

Nursing? ❑ Yes ❑ No

Taking birth control pills? ❑ Yes ❑ No

COMMENTS

I understand the information on both sides of this form 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. If further information is needed, you have my permmission to ask the respective health care provider or agency, who may release such information to you . I will notify Doctor Macias of any change in my health or medication. The undersigned hereby authorizes Doctor Macias to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor Macias to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor Macias to perform any and all forms of treatment and therapy, that may be indicated in connection with patient. I further authorize and consent that Doctor Macias choose and employ such assistance as deemed fit.

Patient Signature ______________________________ Date __________

Parent/Responsible Party Signature ______________________________ Date __________

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication Taken for: ____

Medication Taken for: ____

Medication Taken for: ____

Have you ever taken any medications to strengthen your bones? Please describe.

Do you or have you ever had a substance abuse problem?

Do you chew or smoke tobacco?

Have you noticed any changes in your face or jaws?

Any other physical problems?

How often do you brush?

How often do you floss?

Women: Are you pregnant? Yes No Are you trying to become pregnant? Yes No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders:

Diabetes:

Arthritis:

Severe allergies:

Unusual dental problems:

Jaw size imbalance:

Other family medical conditions?

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RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature ______________________________ Date ______________________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature ______________________________ Date ______________________