ADULT PATIENT REGISTRATION

Name _____ (_____) SSN _____ Driver's License # _____
First Middle Last Preferred Name

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email Address _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation _____

Spouse name _____ Spouse's Birthdate _____

Spouse employed by _____ Business Phone (_____) _____

Are you a full time student? _____ Where? _____ Preferred Pharmacy _____ Phone (_____) _____

Next of Kin / Person to Contact in Case of Emergency

Name: _____ Relationship to Patient: _____

Home Phone (_____) _____ Work Phone (_____) _____

Home Address _____ City _____ State _____ Zip _____

Primary Dental Insurance

Insured's Full Name _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's SSN _____

Insured's Employer _____ Dental Insurance Co. _____

Group # _____ Employee ID # _____

Secondary Dental Insurance

Insured's Full Name _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's SSN _____

Insured's Employer _____ Dental Insurance Co. _____

Group # _____ Employee ID # _____

We will file secondary insurance only if your primary insurance sends our office an explanation of benefits.
We cannot wait on payment from the secondary carrier.

Who may we thank for referring you to our office? _____

I authorize Madison Dental Associates, P.C. to release any information necessary to process my insurance claim and authorize payment to the provider. I am financially responsible for any services both covered and non-covered by insurance.

Date _____ Signature _____

MEDICAL HISTORY

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑
Are you currently experiencing dental pain or discomfort?	❑	❑
Do you have clicking, popping or discomfort in the jaw?	❑	❑
Do you brux or grind your teeth?	❑	❑

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No
Are you now under the care of a physician?	❑	❑

Physician Name: Phone: *Include area code*

Address/City/State/Zip

	Yes	No
Are you taking or have you recently taken any prescription or over the counter medicine(s)	❑	❑

If so, please list all _____

_____

	Yes	No
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	❑	❑
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?	❑	❑
Do you use tobacco (smoking, snuff, chew)?	❑	❑

If so, how interested are you in stopping?

(Circle one) VERY / SOMEWHAT / INTERESTED

WOMEN ONLY Are you:

Pregnant?	❑	❑

Number of weeks: _____

Taking birth control pills or hormonal replacement?	❑	❑
Nursing?	❑	❑

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ❑ ❑

Allergies - Are you allergic to or have you had a reaction to:

To all yes responses, specify type of reaction

	Yes	No
Local anesthetics _____	❑	❑
Penicillin or other antibiotics _____	❑	❑
Metals _____	❑	❑
Latex (rubber) _____	❑	❑

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Heart murmur	❑	❑
Mitral valve prolapse	❑	❑
Artificial heart valves	❑	❑
Cardiovascular disease	❑	❑
Angina	❑	❑
Congestive heart failure	❑	❑
Damaged heart valves	❑	❑
Heart attack	❑	❑
Date _____		
Low blood pressure	❑	❑
High blood pressure	❑	❑
Congenital heart defects	❑	❑
Rheumatic heart disease	❑	❑
Abnormal bleeding	❑	❑
AIDS or HIV infection	❑	❑
Asthma	❑	❑
Emphysema	❑	❑
Tuberculosis	❑	❑
Cancer/Chemotherapy	❑	❑
Date _____		
Diabetes Type I or II	❑	❑
Hepatitis, jaundice or liver disease	❑	❑
Osteoporosis	❑	❑
Sexually transmitted disease	❑	❑

	Yes	No
Has a physician recommended that you take antibiotics prior to your dental treatment?	❑	❑

Name of physician making recommendation: _____ Phone ( ) _____

	Yes	No
Do you have any disease, condition, or problem not listed above that you think we should know about?	❑	❑

Please explain: _____