Enchanting Dentistry
Your smile is our passion

Welcome to our office.
Our goal is to provide you the best quality care available with the most exceptionally friendly service. We believe strongly in preventative dental care and providing you with the most up-to-date information you need to best care for your oral health.

PATIENT REGISTRATION

** Required Fields*

*First Name: _____ Last Name: _____ Middle Initial: ____

*Address: _____

*City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ *Cellular Phone: _____

Sex: Male ____ Female____ Marital Status: Married___ Single___ Divorced___ Separated ___ Widowed___

Birth date: _____ Age: _____ Social Security: _____

*Email: _____ *(used only for Confirmation / Appointment Purposes)*

**How did you hear about us*
Referred By: _____ Last Dental Visit: _____

Emergency Contact: _____ Phone #:_____

What expectations do you have of our dental practice? (Please check all that apply)

- Want to get out of pain / (minimum care) _____
- Want Cosmetic / Restorative care _____
- Want Preventative care / Want to keep my teeth healthy _____

Is there anything about your smile that you would like to improve or change? (Please check all that apply)

- Chipped tooth
- Missing teeth
- Loose fitting partial
- Bad breath
- Silver fillings
- Veneers
- Discolored Teeth

In the past, what has been the biggest obstacle between you and your dental treatment? (Check all that apply)

- Fear of the dentist
- Financial concerns
- Confusion about treatment

Please sign to indicate you have read the Office Procedures and Authorization For Release of Health Information

Print name _____ Sign _____ **Date: _____**

Welcome to Enchanting Dentistry
Please let us know how we can make your visit more comfortable.

INSURANCE...AND OUR OFFICE.

"We consider it an honor to give you the best restorative, preventative and cosmetic care. In fact, we provide several payment options and have even chosen to accept insurance because we feel that these can be great benefits for many patients. Still, we ask you to keep in mind that Dr. Middelhof and other top rated dentists will always recommend treatment based strictly on your actual dental health needs, and not solely on insurance coverage parameters. We will do everything in our power to request the appropriate benefits allotted by your insurance contract while also providing generous options to help you get the care you truly deserve."

If you have insurance, please indicate below. Insurance coverage is NOT required to receive treatment.

Do you have MEDICAL Insurance? _____No _____Yes
Provider_____ Provider phone _____
Group # _____ ID #:_____
Subscriber's name _____ Date of birth _____
Employer _____

Do you have DENTAL Insurance? _____No _____Yes
Provider_____ Provider Phone _____
Group # _____ ID #:_____
Subscriber's name _____ Date of birth _____
Employer _____

Please be prepared to present identification cards and insurance cards to front desk.

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Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	○ Yes ◉ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ◉ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	If yes would you like information on medication to aid in quiting

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Glaucoma	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Hay Fever	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Fearful/Anxiety	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No			Psychiatric Care	○ Yes ○ No		
Yellow Jaundice	○ Yes ○ No						

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments: *Any special requirements or concern not related to in this form? Please use the space to type below*

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date :_____