DeMercy Dental
10930 Crabapple Road, Ste. 140
Roswell, GA 30075
770-641-8010
www.demercydental.com

PATIENT REGISTRATION

(Please print)

Patient's Legal Name:_____
Last First Middle
Preferred Name:_____
Street Address:_____
_____
City St Zip
Phone Numbers: _____ _____ _____
Home Cell Work
Email address:_____
Which method is best to confirm appointments with you? ___Cell phone
___Home phone ____Work Phone ___Email
Marital Status Single Married Widow Other Sex: __Male __Female
Birthdate: ___/___/____ Social Security #:___/__/____
Driver's License: _____ State Issued:____ Exp. Date:_____
Occupation:_____
Employer:_____
How did you hear about us? Family/Friend:_____ Mailer:_____
Website:_____Google:_____ Dr._____Other_____
Whom may we contact in case of an emergency? Name:_____
Phone Number:_____Relationship:_____

ACCOUNT INFORMATION

Person responsible for account:
Name:_____Relationship:_____Phone:_____
Address:_____
Primary Insurance Company:_____
Subscriber's Name:_____Subscriber's Birthdate:_____
Social Security Number:_____
Employer:_____
Group Number:_____ Member ID:_____
Insurance Phone Number:_____
Insurance Address:_____

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims on my behalf. I certify this information is true and correct to the best of my knowledge. I will notify DeMercy Dental of any changes.

_____Date:_____
Patient Signature

Patient Name: _____ Date of Birth: _____

Dental History

How many times a day do you brush? ____ How often do you floss? ____

Have you ever been diagnosed with periodontal disease? **Y** or **N**

Do you have any of the following:

discomfort/clicking in jaw lost/broken fillings sensitive teeth grinding/clenching teeth locking jaw
bad breath red/swollen/bleeding gums blisters/sores in or around mouth broken/chipped teeth

Medical History

Indicate which of the following conditions you have or have had with a check in the box. Leaving blank will indicate a NO response.

- ☐ AIDS
- ☐ Arthritis
- ☐ Back Problems
- ☐ Blood Transfusion
- ☐ Chest Pains
- ☐ Difficulty breathing
- ☐ Fainting or dizziness
- ☐ Headaches
- ☐ Hepatitis A B C
- ☐ Jaundice
- ☐ Low Blood Pressure
- ☐ Nervous Disorders
- ☐ Seizures
- ☐ Stomach problems
- ☐ Tuberculosis
- ☐ Allergies
- ☐ Artificial Joint
- ☐ Birth Control Pills
- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Attack/Stroke
- ☐ Herpes
- ☐ Kidney Disease
- ☐ Respiratory Problems
- ☐ Shingles
- ☐ Stroke
- ☐ Tumors
- ☐ Anemia
- ☐ Artificial Valve
- ☐ Chemical dependency
- ☐ Epilepsy/Seizures
- ☐ Hay Fever/Seasonal Allergies
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Latex Allergy
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease
- ☐ Ulcers
- ☐ Aneurism
- ☐ Asthma
- ☐ Blood Disease
- ☐ Chemo/radiation therapy
- ☐ Diabetes **Latest A1C:** _____
- ☐ Excessive Bleeding/Hemophilia
- ☐ Head Injuries
- ☐ Heart Murmur
- ☐ HIV+
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoarthritis
- ☐ Sinus Problems
- ☐ Thyroid Problems
- ☐ Sexually Transmitted Disease

If yes to any of the above, please explain any further details:

_____

_____

_____

Do you require antibiotic pre-medication for any reason, including artificial joints/valves? Y or N
Have you ever taken osteoporosis medications or had injections? Y or N

Allergies

Do you have any allergies to the following: Latex Penicillin/Amoxicillin Tetracycline Aspirin

Dental Anesthetic Codeine Sulfa

Other: _____

Medications

Please list ALL medications you are currently taking, including supplements/vitamins:

_____

_____

_____

_____

Primary Physician's Name: _____ **Phone Number:** _____

Social History

Have you ever habitually used tobacco products? Y or N

What type of tobacco? Cigarettes Cigars/Pipe Dip Chewing Tobacco

How often?_____ How long? _____

Do you drink alcohol? Y or N

How many servings do you consume on average a week?_____

For Women: Are you currently pregnant? Y or N Breast Feeding? Y or N

General Consent for Treatment

We are pleased you have chosen our office for your oral healthcare and we are committed to providing the highest level of treatment and customer service in dentistry. If there is any way we can improve what we do please let us know. Please read the following and sign your acceptance of general consent for treatment at our office.

1. We will use radiographs (x-rays) of your teeth and tissues to discern the presence of disease and other conditions in your bony or calcified tissues. These radiographs which show between the teeth once per year during regular examination and panoramic or full mouth series once every 3-5 years depending on what the doctor determines is best for each individual patient. Other radiographs will be taken as needed to document the presence or progress of any disease condition you may experience.
2. Our procedures may at times require the use of local anesthetics to numb your teeth and tissues to allow your greatest comfort during care. Dental anesthetics on rare occasion involve some bruising of involved tissues and may very rarely have an adverse effect of prolonged or permanent anesthesia. Sometimes medications you are taking either prescribed, over the counter, or herbs/supplements-may have an adverse interaction with anesthetics. Please let us know if you are taking any of these substances to avoid any complications.
3. As in any healthcare environment there may be adverse effects or unanticipated needs which apply to the particular treatment you are undergoing. These effects may or may not be limited to other procedures related to but unanticipated at the time of diagnosis: i.e., root canal, crown lengthening, or placing a crown instead of a large filling, temporary or long term discomfort or sensitivity due to placement of restorative material. We will make every attempt to anticipate and/or correct any unforeseen situations. We may at times elect to refer you to a dental specialist that performs the necessary procedure. We strongly encourage our patients to ask questions and understand each procedure before it is performed.
4. At times, pictures of your teeth and smile may be used to communicate with various laboratories or treatment specialists to obtain the highest level of care available. We want you to know these pictures will be used in only this way unless otherwise specified in another agreement.
5. Additional informed consent will be required before we perform procedures involving teeth which require root canal or extractions.

Signature: _____ **Date:** _____