AFFORDABLE & AESTHETIC DENTAL CENTER

303 Post Office Rd. Suite B-1, Waldorf, MD – 20602
(301)396-3333

Registration Form / Dental History

PATIENT INFORMATION
(Confidential)

Date: _____

Patient#: (Leave Blank): _____

Name: _____ Social Security #:____-____-_____ Birth Date: _____
Mailing Address: _____ City_____ State____ Zip_____
Home Phone: _____ Cell: _____ E-mail: _____
Circle one: Minor Single Married Partnered Divorced Separated Widowed

Patient's Employer (If minor, then Parent's Info): _____ Work Phone: ____
If minor, then parent's name_____ Birth Date _____
Social Security#_____-_____-_____ Cell _____

Spouse's Name (If minor, then other Parent's Name): _____ Birth Date: _____
Social Security#_____-_____-_____ Work Phone: _____ Cell _____
Employer: _____

Who is financially responsible for this account? (Do not list your insurance co.)_____
Person to Contact in Case of Emergency: _____ Phone: _____
How did your hear about our office? _____

DENTAL HISTORY

Reason for today's visit _____
Date of last dental visit _____ Date of last dental x-rays _____

Do you have or have you ever had any of the following conditions with your mouth or teeth?

Mouth (Check all that apply)

__Difficulty opening/closing jaw __Bleeding, sore gums
__Unpleasant taste/bad breath __Clicking/popping jaw
__Burning tongue/lips __Ortho treatments (braces)
__Frequent blisters, lips/mouth __Biting Cheeks/lips
__Swelling/lumps in mouth

Teeth (Check all that apply)

__ Loose Teeth __ Clenching/grinding teeth
__Sensitive to hot __Shifting teeth
__ Sensitive to cold __Change in bite
__Sensitive to sweet __Food impaction
__ Sensitive to biting

How often do you brush? _____ What type of brush (circle one): Soft Medium Hard
How often do you floss? _____ What other mouth products do you use? _____

PLEASE TURN OVER

Medial History

Physician's name_____ Date of last visit_____

Please CIRCLE if you have or had any of the following:

Heart failure	Kidney Disorders	Alcoholism
Heart Disease/Attack	Ulcers	Drug Addiction
Angina Pectoris	Use of Tobacco Products	Glaucoma
High Blood Pressure	Emphysema	Cortisone Medicine
*Mitral Valve Prolapse	Tuberculosis (TB)	Hepatitis (Type_____)
*Heart Murmur	Asthma	Liver Disease
*Rheumatic Fever	Sinus Problems	Jaundice
*Congenital Heart Lesions	Rash/Hives	Blood Transfusion
Heart Pace Maker	Allergies/ Hay Fever	Bleeding Disorder
Heart Surgery	Diabetes	Bruise Easily
Herpes	Radiation Treatment	Cancer/Tumor/Growth (Type_____)
Anemia	Chemotherapy	*Any Type of Implant
Stroke	Arthritis	*Any Type of Transplant
Epilepsy or Seizures	Fainting or Dizzy Spells	Loss of Hearing
Psychiatric Treatment	Sickle Cell Disease	Headaches
*Artificial Hip, Knee, or other Joint	HIV Pqstive, ARC, AIDS	Thyroid Condition
Low Blood Pressure	Venereal Diseases	

**Antibiotic premedication may be required prior to your appointment*

Please list all other illnesses not shown above: _____
Please list any major operation/s? _____

Have you ever had excessive bleeding following an extraction or do cuts take longer to heal now than previously? Yes No

(**Women Only**) Are you pregnant? Yes No Are you nursing? Yes No
Are you taking birth control? Yes No

MEDICATIONS

List all medications that you are currently taking, (Including over the counter): _____
_____
_____
_____
_____

ALLERGIES (Check all that apply)

__ Local Anesthetics __ Codeine
__ Barbituates/Sleeping Pills __ Aspirin
__ Penicillin __Latex
__ Sulfa __Metals
__Other allergies not listed here_____
_____
__ No Known Allergies

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient/Parent/Guardian _____Date_____

Signature of Dentist_____Date_____

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PAYMENT OPTIONS

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE AVAILABLE UPON REQUEST AT THE TIME OF YOUR VISIT. If you need a payment arrangement please discuss with our office staff.

Please select one of the following payment options:

_____ Payment by cash _____ Health Spending Account (HSA)

_____ Payment by Visa or Mastercard

_____ Carecredit (Payment Plan) Upon Approval Existing Cardholder **Yes/No**

Our office is fully approved and an accredited user of the visa and mastercard Healthcare program, which will enable you to use visa/mastercard to automatically cover amounts not paid by your insurance.

MISSED/ CANCELLED APPOINTMENTS

We greatly appreciate your business and are striving to better serve you. Due to the increase in patient volumes we need to enforce new policies:

A $25 charge will be applied for all missed appointments.

A $25 charge will be applied for all appointments canceled without a 24- hour notice.

A $50 charge will be applied for all crown, bridge and veneer appointments that are missed or cancelled without a 24- hour notice.

All appointments must remain on time, if you are 15 minutes late your appointment may be rescheduled. We thank you for your understanding regarding our office policies. If you have any questions please feel free to ask.

_____ _____

Patient/Guardian Signature Date

_____

Printed Name