Nancy K. Pruett, D.D.S.
4715 Statesmen Drive, Suite G, Indianapolis, IN 46250
Tel 317-284-1850 Fax 317-284-1843

PATIENT REGISTRATION FORM

Today's Date: _____

Patient Name: First_____Last_____MI_____

E-mail: _____Cell Phone: ( ) _____-_____

Home Phone: ( ) _____-_____ Work Phone: ( )_____-_____

Mailing Address: _____Apt #_____City/State_____

Zip_____ Date of Birth: _____ Sex: M F

Employer: _____Occupation:_____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY NOTIFY

Name _____ Home #_____ Cell# _____

INSURANCE

Name of Insured_____ Relationship to patient _____Birthdate_____

SSN_____ Employer_____ Work Phone_____

Insurance Company_____ ID#_____ Group #_____

Claims Address: _____City/State_____Zip____

Secondary Insurance: _____Name of Insured_____

Relationship to Patient_____

Consent To Treat And Financial Responsibility

The undersigned herby authorizes Dr. Pruett and staff to perform any diagnostic aids deemed necessary to make a thorough diagnosis of my needs. I also authorize Dr. Pruett and staff to perform any and all forms of dental treatment and therapy that may be indicated.

In consideration of treatment rendered the above named patient, I accept full financial responsibility. Insurance forms will be completed as a convenience to the patient; however, payment is required at the time services are rendered, unless other arrangements are made in advance. I further agree that appointment cancellations must be **48 hours** prior to scheduled appointment or will be subject to a **$25 fee**. I understand that all fees that are not covered by insurance are my financial responsibility. Initial_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the office's Notice of Privacy Practices. I agree to be contacted by phone, email, fax or U.S. mail to convey information about appointments, lab test results, clarify medication dosages, or answer simple dental or insurance questions. You may leave a message on voice mail. You may disclose information to the following family members and/or non-family members.

Name: _____ Phone #: _____ Relationship: _____

Signature (patient, parent or legal guardian) _____Date: _____

Printed Name (patient, parent or legal guardian) _____

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MEDICAL HISTORY

Patient's Name_____
Last First MI Date of Birth

Physician's name, address and phone_____
Have you been seen by a physician in the past 2 years? YES NO If yes, why? _____
Have you been hospitalized in the past 5 years? YES NO If yes, why? _____
Have you ever had any operations or surgery? YES NO If yes, why? _____
Have you ever had prolonged or excessive bleeding that required special treatment? YES NO

Have you ever had any of the diseases or conditions listed below? (Please circle YES or NO)

Heart Problems	YES NO	Sinus Trouble	YES NO
• mitral valve Prolapse	YES NO	Allergies or Hives	YES NO
• heart murmur	YES NO	Diabetes	YES NO
• artificial heart valve	YES NO	Cancer or Tumor	YES NO
• heart pacemaker	YES NO	Radiation or Cobalt	YES NO
• congenital heart lesions	YES NO	Chemotherapy	YES NO
• heart surgery	YES NO	Arthritis	YES NO
• heart disease or attack	YES NO	Cortisone Medications	YES NO
• heart failure	YES NO	Glaucoma	YES NO
• angina pectoris	YES NO	Hepatitis	YES NO
Artificial Joints/prosthesis	YES NO	Yellow Jaundice	YES NO
Rheumatic Fever	YES NO	Blood Transfusion	YES NO
High Blood Pressure	YES NO	Alcohol or Drug Addiction	YES NO
Anemia	YES NO	Hemophilia	YES NO
AIDS (HIV+)	YES NO	Venereal Disease	YES NO
White Patch in Mouth	YES NO	Genital Herpes	YES NO
Stroke	YES NO	Cold Sores or Fever Blisters	YES NO
Kidney Trouble	YES NO	Epilepsy or Seizures	YES NO
Ulcers	YES NO	Fainting or Dizzy Spells	YES NO
Emphysema	YES NO	Nervous Disorder	YES NO
Enlarged Lymph Node	YES NO	Psychiatric Treatment	YES NO
Chronic Cough	YES NO	Sickle Cell Disease	YES NO
Tuberculosis (TB)	YES NO	Thyroid Disease	YES NO
Asthma	YES NO	Hay Fever	YES NO

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List all prescription, over-the-counter and herb medications that you are taking and the reason you are taking them. _____

_____

_____

Do you have allergic or other unusual reactions to the following? YES NO If yes, circle:
Penicillin Aspirin Codeine Sulfa Dental Anesthetics Metals Latex

Other allergies (please list): _____

Do you smoke, chew, use snuff or any other forms of tobacco? YES NO
If yes, how many years and how many packs a day? _____

Do you have family history of sleep-disorder-affected breathing? YES NO
Do you have frequent complaints of unrefreshing sleep and daytime sleepiness? YES NO
Do you have history of snoring, especially load snoring? YES NO
Have you experienced sleep punctuated by episodes of choking, gasping, breath holding or snorting? YES NO

Do you have any other disease or condition not mentioned above? YES NO

_____

<u>WOMEN ONLY</u>

Are you currently pregnant or breastfeeding? YES NO
If yes, what trimester are you in? (How many weeks?) _____
Are you taking birth control pills or using other contraceptive medications? YES NO

DENTAL HISTORY

Purpose of initial visit _____
Have you had regular visits? YES NO
How often: 3 months 4 months 6 months
How long since your last dental visit? _____
What was done at your last dental visit? _____
When was the last time your teeth were cleaned? _____
Previous Dentist's Name: _____
Phone #: _____

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CAVITY RISK ASSESSMENT:

Do you have Fluoride Exposure: YES NO

If yes, please circle:

- Drinking Water
- Toothpaste
- Supplements
- Home fluoride gel/rinse
- Dental office

Are your teeth sensitive to hot, cold, sweets or pressure? YES NO

Does food or floss catch between your teeth? YES NO

Is your mouth dry? YES NO

Sugary or starchy foods or drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups) YES NO

Cavities in the last 2 years YES NO

Teeth missing in the past 2 years due to cavities YES NO

General Questions

Have you ever had any problems or complications with previous dental treatment? YES NO

Are any of your teeth loose, tipped, shifted or chipped? YES NO

How often do you brush your teeth? 1 x/day 2 x/day After each meal

What kind of toothbrushes do you use? Manual Electric

How often do you floss you teeth? 1 x/day 2 x/day After each meal

Have you lost any teeth/have any teeth been removed? YES NO

- If so, Why? _____
- Have they been replaced? YES NO
- Are you happy with the replacement? YES NO
- If no, explain _____

TMJ

Do you clench or grind your teeth? YES NO

Does your jaw click or pop? YES NO

Have you experienced any pain or soreness in the muscles on your face or around your ear? YES NO

Do you have frequent headaches, neck pain or shoulder pain? YES NO

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PERIODONTAL DISEASE:

Do your gums bleed when you brush and floss?	YES NO
Do you feel your breath is offensive at times?	YES NO
Have you had any periodontal treatment in the past?	YES NO

Are you presently satisfied with the condition of your mouth and teeth?

- Very Satisfied
- Satisfied
- It's OK
- Somewhat dissatisfied
- Very dissatisfied

To the best of my knowledge, all of the information provided on this registration form is correct.

_____ _____

Signature of Patient, Parent or Legal Guardian Date