PATIENT REGISTRATION

ID: ______ Chart ID: ______

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: ______

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Adress 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc. Sec: ______ Drivers Lic: ______

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ______ Adress 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Age: ______ Soc. Sec: ______ Drivers Lic: ______

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

E-mail: ______ I would like to receive correspondences via e-mail ☐

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ______ Pref. Dentist: ______

Employer ID: ______ Pref. Pharmacy: ______

Carrier ID: ______ Pref. Hyg.: ______

Last Dental Visit ? : ______

Do you like your smile ? : ______

Last Cleaning ? : ______

Any Problems ? : ______

Are you in pain ? : ______

Insurance Information

Name of Insured: ______ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2: ______

City, State, Zip: ______

Rem. Benefits: ______.00 Rem. Deduct: ______.00

Ins. Company: ______

Address: ______

Address 2: ______

City, State, Zip: ______

If you have any questions regarding this information or any uncertainty regarding insurance coverage, **PLEASE** let us know right away! We are here to work for you and with you!

NAME:

HOME NUMBER: CELL: WORK:

HOME ADDRESS:

CITY: ZIP CODE:

PERSON RESPONSIBLE FOR PAYMENT:

I WILL BE PAYING TODAY BY: ☐ CASH ☐ CEC ☐ CREDIT CARD

I understand and agree that regardless of my dental insurance status, I am ultimately responsible for the balance of my account with Dr. Isabel David's office. I have read the information on this form and I I have answered all questions. I certify that is information is true and correct to the best of my knowledge. I will notify Dr. Isabel David's office of any changes regarding my health, change of address, and/or of dental insurance coverage.

SIGNATURE OF PATIENT:

IF MINOR, SIGNATURE OF PARENT/GUARDIAN:

TODAY'S DATE:

SLEEP QUESTIONAIRE

Have you ever been told you stop breathing while asleep?	☐ Yes	☐ No
Have you ever fallen asleep or nodded off while driving?	☐ Yes	☐ No
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	☐ Yes	☐ No
Do you fell excessively sleepy during the day ?	☐ Yes	☐ No
Do you snore or have you ever been told that you snore ?	☐ Yes	☐ No
Have you had weight gain and found it difficult to lose weight?	☐ Yes	☐ No
Have you take medication for, or been diagnosed with high blood pressure ?	☐ Yes	☐ No
Do you kick or jerk your legs while sleeping ?	☐ Yes	☐ No
Do you feel burning, tingling or crawling sensation in your legs when you wake up?	☐ Yes	☐ No
Do you wake up with headaches during the night or in the morning?	☐ Yes	☐ No
Do you have trouble falling asleep?	☐ Yes	☐ No
Do you have trouble staying asleep once you fall asleep?	☐ Yes	☐ No

HEAD, NECK & FACIAL PAIN

Headaches or migraines	☐ Yes	☐ No
Earaches, stuffiness or ringing in the ears	☐ Yes	☐ No
Pain behind the eyes	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Limited mouth opening	☐ Yes	☐ No
Neck, shoulder, back pain or stiffness	☐ Yes	☐ No
Locking jaw (opened or closed)	☐ Yes	☐ No
Unexplained teeth or facial pain	☐ Yes	☐ No
Numbness in fingers or arms	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No

PATIENT NAME: ____________________