South Clairemont Dentistry

Dr. Nellie P. Molnar

Patient Registration

(PLEASE FILL OUT COMPLETELY IN CLEAR PRINT) Date: _____

Name (First/Last):_____ Birthdate: _____ SSN #_____
Address:_____ City: _____ State: _____ Zip: _____
Email: _____
Home Phone: _____ Cell Phone: _____ Sex: Male _____ Female_____
Single ___ Married ___ Widowed ___ Minor ___ How Did You Hear About Us?_____
Employer: _____ How Long: _____ Business Phone: _____
Emergency Contact: _____ Phone: _____ Relationship:_____
Name of Parent/Guardian: _____ Contact #: _____

Dental History

Current Dentist: _____ Contact #: _____
Date of most recent exam: _____ Date of most recent X Rays: _____
Reason for today's visit? _____

Have you had treatment for your current issue before? Yes ____ No____ If Yes, what treatment and when?_____
_____

Do you grind your teeth?	Yes___ No___	Are your teeth sensitive to hot/cold?	Yes___ No___
Do you have a negative reaction to Novocain?	Yes___ No___	Do you floss regularly?	Yes___ No___
Have you had difficult extractions in the past?	Yes___ No___	Do you have sensitive gums?	Yes___ No___
Do you have trouble chewing?	Yes___ No___	Do you have trouble getting numb?	Yes___ No___
Any jaw problems? (popping, locking, clicking)	Yes___ No___	Do you have a removable appliance?	Yes___ No___
Do you have bad breath?	Yes___ No___	Do you have dry mouth?	Yes___ No___

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 hav or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Information provided is strictly confidential and will not be released without your permission. Thank you for answering the following questions.

MEDICAL HISTORY

Height: _____ Weight: _____ Are you in good health? Yes____ No____
If NO, *or* currently under the care of a physician please explain: _____
_____
Current Physician: _____ Contact: _____ Last Visit: _____
Cardiologist: _____ Contact: _____ Last Visit: _____
Have you had any surgical procedures or had any serious illness within the past 5 years? Yes____ No____
If YES, please explain in detail: _____
_____

Do you have a: Pacemaker ____ Defibrillator ____ Heart Stent____ None____

Have you ever taken Fosamax, Boniva, Celebrex, Prednisone or any other bisphosphonate or chemotherapeutic agent? Yes___ No___

PLEASE LIST ALL MEDICATIONS: (check if) NONE_____

Name_____ / Dose_____
Name_____ / Dose_____
Name_____ / Dose_____
Name_____ / Dose_____

Name_____ / Dose_____
Name_____ / Dose_____
Name_____ / Dose_____
Name_____ / Dose_____

ALLERGIES

Latex	Yes___ No___	**Pollen**	Yes___ No___	**Eggs**	Yes___ No___
Penicillin	Yes___ No___	**Codeine**	Yes___ No___	**Antibiotics**	Yes___ No___
Aspirin	Yes___ No___	**Sulfa Drugs**	Yes___ No___	**Metals**	Yes___ No___
Barbiturates	Yes___ No___	**Local Anesthesia**	Yes___ No___	**General Anesthesia**	Yes___ No___

Have you been diagnosed with any of the following conditions?

Anemia	Yes___ No___	**Headaches/Migraines**	Yes___ No___
Arthritis Where: _____	Yes___ No___	**Lupus**	Yes___ No___
Asthma Require an inhaler: _____	Yes___ No___	**Neurological problem**	Yes___ No___
Bleeding Disorder	Yes___ No___	**Organ Transplant When/Where:** _____	Yes___ No___
Breathing Problems	Yes___ No___	**Osteoarthritis Where:** _____	Yes___ No___
Cancer Where &When: _____	Yes___ No___	**Osteoporosis Where:** _____	Yes___ No___
Chemo/Radiation When: _____	Yes___ No___	**Panic Attacks Cause:** _____	Yes___ No___
Chest Pain	Yes___ No___	**Digestive Disorder**	Yes___ No___
Chronic Bronchitis	Yes___ No___	**Replaced Heart Valve When:** _____	Yes___ No___
Circulatory Problems	Yes___ No___	**Rheumatic Fever**	Yes___ No___
Heart Problems	Yes___ No___	**Rheumatoid Arthritis**	Yes___ No___
Diabetes - Type: _____	Yes___ No___	**Sinus Problem**	Yes___ No___
Epilepsy/Seizures Last Episode: _____	Yes___ No___	**Sleep Apnea/CPAP**	Yes___ No___
Fainting Cause: _____	Yes___ No___	**Stroke When:** _____	Yes___ No___
Healing Problems	Yes___ No___	**Thyroid Problems**	Yes___ No___
Heart Attack When: _____	Yes___ No___	**Trauma to Head/Neck When:** _____	Yes___ No___
Heart Stent When: _____	Yes___ No___	**Tuberculosis**	Yes___ No___
Hepatitis - What kind: _____	Yes___ No___	**Ulcers/Gastric Reflux**	Yes___ No___
Artificial Joints Where _____	Yes___ No___	**Use of Alcohol How often:** _____	Yes___ No___
Pre Medication Required	Yes___ No___	**Use of Drugs What kind:** _____	Yes___ No___
Kidney Disease	Yes___ No___	**Use of Tobacco How much:** _____	Yes___ No___
High Blood Pressure	Yes___ No___	**Low Blood Pressure**	Yes___ No___
Liver Disease	Yes___ No___	*Women:* **Are You Pregnant**	Yes___ No___
STD What kind: _____	Yes___ No___	*Women:* **Are You Nursing**	Yes___ No___
HIV / AIDS	Yes___ No___	*Women:* **Are You Taking Birth Control**	Yes___ No___

Please list any other conditions: _____

_____

IF YOU HAVE INSURANCE ...

So that you don't have to sign an insurance form at each dental visit Nellie Molnar DDS, will maintain a "signature on file" for you. I hereby authorized Nellie Molnar DDS to release any information including the diagnosis and the records of any treatment or examination rendered to my insurance provider. I request my insurance to make payment directly to the dentist or dental group otherwise payable to me. As a courtesy to you, we will verify benefits with your insurance carrier, and based on the information we receive, will estimate your out of pocket expenses. However, in no way should this estimate be considered a guarantee of payment. Actual benefits will b determined by your insurance company when your claims are reviewed & processed by their insurance claim specialists. In the event we do accept assignment of benefi and your insurance company has not paid your account in full within 60 days or your insurance terminates, the balance will be transferred to your account.

Authorization and Acknowledgment

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status. I consent to treatmei as necessary or desirable for diagnosis of dental disease, treatment and dental emergencies. In case of an emergency, I consent to treatment for that emergency. I understand that my doctor will discuss alternative forms of treatment as well as their risks and benefits. I have the right to decline treatment plans based upon the evaluation to which I am consenting. I understand that I am responsible to visit a dentist for regular cleanings to maintain my dental health. I fully understand and agree to the terms of the office policy that I am ultimately responsible for my account balance and I authorize the office to contact me via the contacts listed on the registratic form regarding insurance and billing inquiries. My signature below confirms that I have read and understand everything pertaining to health, insurance and my financial responsibility as it has been explained to me by Nellie Molnar DDS and/or staff.

Patient (Guardian) Signature: _____ **Date:** _____