Silver Spring Dental Care
13321 New Hampshire Ave, Ste 201
Silver Spring, MD 20904
301-384-6600
301-384-6622 (fax)

PATIENT'S REGISTRATION

Patient's Name _____Birth date _____Sex: M F
Address _____Apt# _____Marital Status: S M D
City _____State _____ZIP Code: _____
Soc. Security # _____Home phone _____Work phone: _____
If a full-time student, what school are you enrolled? _____
Employer's name _____Occupation _____Cell # _____
How did you hear about our practice? _____ E-Mail: _____

Person responsible for account (if different from above)
Relationship to patient: ( )self ( )spouse ( )parent/guardian *If self, skip to insurance section*
Name _____Birth date _____Sex: M F
Does this person & the patient reside in the same household? Yes No SS# _____
Address _____Apt # _____City _____
State _____Zip Code _____ Home # _____ Work # _____

Is patient covered by primary dental insurance? YES NO
Insurance Co _____Employer's Name _____
Employee's name _____Birth date _____Sex: M F
SS# or subscriber number (shown on card) _____Group # _____
Insurance company's phone **#** _____
Address _____
Relationship to patient: ( )Self ( )Spouse ( )Parent/Guardian

Is patient covered by secondary dental insurance? YES NO
Employee's name _____Birth date _____Sex: M F
SS# or subscriber number (shown on card) _____Group # _____
Insurance Co _____Employer's Name _____
Relationship to patient: ( )Self ( )Spouse ( )Parent/Guardian

NOTE: Due to frequent changes in insurance rules and regulations, benefits and deductibles, we can only approximate the amount that your insurance will pay. If your insurance pays more than expected you will be credited with the difference. If your insurance company pays less than expected you will be billed for the difference. I authorize **Silver Spring Dental Care** to apply for benefits on my behalf for the services rendered to me (or minor child) and direct that payments to be sent to **Silver Spring Dental Care**. I understand that such authorization does not relieve me of my primary responsibility to pay for services rendered to me (or minor child) and for expenses that will result from any collection action that may be necessary.

Date _____Signature _____
(Update) Date _____Signature _____
(Update) Date _____Signature _____

(OVER)

Patient Name _____ **Medical History**

Your answers to the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential.

Do you have or have you ever been treated for:

	YES	NO		YES	NO		YES	NO
Any heart problems			Sickle-cell trait			Liver problem or dysfunction		
Heart attack			Blood transfusion			Adrenal or pituitary problem		
Angina			Sexual transmitted disease			Hepatitis or jaundice		
Bypass			Other infectious disease			Kidney problem/dysfunction		
Pacemaker			Chemotherapy/radiation			Stomach trouble/ulcer		
Stroke			Are you pregnant?			Alcoholism		
High blood pressure			Other growths			Drug abuse		
Low blood pressure			Cancer or tumor			Nervous or mental disorder		
Do you need to pre-med			HIV/ AIDS			Epilepsy or seizures		
Heart murmur			Do you smoke?			Thyroid problems		
Mitral-valve prolapse			Lung/breathing problems			Allergy to erythromycin		
Heart-valve defect			Asthma			Allergy to codeine		
Heart-valve replacement			Bronchitis			Reaction to local ansthesia		
Rheumatic fever **			Emphysema			Allergy to penicillin		
Artificial joint **			Tuberculosis			Allergy to sulfa drugs		
Bleeding disorder			Sinus trouble			Allergy to aspirin		
Anemia			Diabetes			Other allergies		
Hemophilia			Difficulty healing			**List:**		

Do you have any health problems not noted above? ( )Yes ( )No

What? _____

Are you being treated by a physician? _____Why? _____

Physician's name and phone number: _____

Are you taking any medications or pills? _____If yes, please list below.

Drug: _____Purpose: _____

Drug: _____Purpose: _____

Drug: _____Purpose: _____

Emergency contact person(s): _____ _____ _____

Name Relationship Phone

Dental History

Purpose of today's visit. Please check one ( ) Exam & Cleaning ( ) Consultation

( ) Pain & Discomfort ( ) Other _____

Are you aware of a problem: _____

When was your last dental visit: _____When were x-rays last taken: _____

Previous dentist's name and address: _____

When was the last time your teeth were cleaned: _____

Have you ever had an adverse or bad dental experience? _____

If so, please explain: _____

Do you think you have any decay?	YES	NO	Have you had gum surgery?	YES	NO
Do your gums bleed easily?	YES	NO	Do you clench or grind your teeth?	YES	NO
Do you suffer from bad breath?	YES	NO	Interested in perm replacement of teeth	YES	NO
Do you have jaw or joint pain?	YES	NO	Would you like "whiter" teeth?	YES	NO
Are you unhappy w appearance of teeth?	YES	NO	Do you have any concerns?	YES	NO
Are your teeth sensitive?	YES	NO	Do you snore?	YES	NO
If you smoke, would you like to quit?	YES	NO	If yes, would you consider treatment?	YES	NO

I Certify that the above information is complete and accurate. I authorize examination and treatment as necessary, by or under the supervision of the dentist.

Signature (self or patient or guardian) _____ Date _____

Dentist Signature _____ Date _____