KELLER DENTAL
A Family's Family Practice
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6760 Corporate Drive, Suite 270 • Colorado Springs, CO 80919

PATIENT REGISTRATION

Date: _____

Name:_____ Preferred Name:_____

Address:_____Apt #: _____

City: _____State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

Date of Birth:_____ Married: ☐ Yes ☐ No

Social Security #:_____ ☐ Male ☐ Female

Email: _____

How did you hear about our office? _____

**I authorize Keller Dental to release my protected health information (PHI) to the following person(s):

_____

PHI) may include information regarding my dental/medical treatment plans, appointments, billing and account information as well as Insurance and third party financing.

RESPONSIBLE PARTY (if other than patient)

Name: _____Relationship to patient: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

INSURANCE INFORMATION (Please provide insurance card)

Primary Dental Insurance Company: _____ Employer: _____

Subscriber:_____ DOB:_____ ID #_____ Group # _____

Relationship to patient: ☐Self ☐Spouse ☐Parent ☐Domestic Partner

Secondary Dental Insurance Company: _____Employer: _____

Subscriber:_____ DOB:_____ ID #_____ Group # _____

Relationship to patient: ☐Self ☐Spouse ☐Parent ☐Domestic Partner

ASSIGNMENT OF DENTAL BENEFITS. *I authorize Keller Dental to furnish information to my insurance carrier concerning treatment and I assign all insurance payments to this office for dental services rendered to myself or dependents.*

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____DATE:_____

I agree to receive electronic communication from Keller Dental *(i.e.: appointment reminders, receipts, e-mails)* ☐**Yes** ☐**No**

I have received for review a copy of this office's notice of Privacy Practices. **You may refuse to sign this acknowledgement**

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____DATE:_____

I have received the Office Policy form for review. I consent to dental treatment and agree to the payment, appointment, photo and video policies of Keller Dental.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____DATE:_____

MY SMILE

What bothers you about your smile? _____

Are there any spaces that you do not like? ☐Yes ☐ No Are your teeth sensitive to hot, cold, sweets or pressure? ☐Yes ☐ No

Are your teeth as bright as you would like? ☐Yes ☐ No Is crowding a problem? ☐Yes ☐ No

Do you have any discolored, chipped or old fillings that bother you when you smile? ☐Yes ☐ No

How would you like your smile to look? _____

Do you have Jaw pain, clicking or popping, clench your teeth or frequent headaches? ☐Yes ☐ No

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health Problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a Physician's care now? ☐Yes ☐ No If Yes, please explain:_____

Name of Primary Care Physician:_____Phone:_____

Date of last Physical Exam:_____ What is your Height?_____ What is your Weight?_____

Have you ever been hospitalized or had a major operation? ☐Yes ☐ No If Yes, please explain:_____

Have you ever had a serious head or neck injury? ☐Yes ☐ No If Yes, please explain:_____

Do you take any over the counter medications or vitamins? ☐Yes ☐ No If Yes, please list:_____

Are you taking any prescription medications? ☐Yes ☐ No If Yes, please list:_____

_____

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate? ☐Yes ☐ No If Yes, please explain:_____

Are you on a special diet? ☐Yes ☐ No If Yes, please explain:_____

Do you use Tobacco? ☐Yes ☐ No If Yes, please explain:_____

Do you use controlled substances? ☐Yes ☐ No Do you use Medical Marijuana? ☐Yes ☐ No Recreational Marijuana? ☐Yes ☐ No

Do you take pre-medication (antibiotics) prior to your dental appointments? ☐Yes ☐ No

Women Only: *Are you?* ☐*Taking oral contraceptives* ☐*Pregnant/ Trying to get pregnant? If pregnant, how many weeks:_____* ☐*Nursing*

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Dental Anesthetics ☐ Erythromycin ☐ Jewelry ☐ Latex ☐ Metals ☐ Penicillin ☐ Tetracycline

☐ Other/ please explain:_____

Do you have, or have you had any of the following?

Abnormal Bleeding ☐Yes ☐No	Congenital Heart Defect ☐Yes ☐No	Hepatitis A ☐Yes ☐No	Seizures ☐Yes ☐No
Alcohol Abuse ☐Yes ☐No	Cosmetic Surgery ☐Yes ☐No	Hepatitis B or C ☐Yes ☐No	Sexually Transmitted Disease ☐Yes ☐No
Allergies ☐Yes ☐No	Diabetes ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Shingles ☐Yes ☐No
Anemia ☐Yes ☐No	Drug Addiction/Abuse ☐Yes ☐No	HIV/ AIDS ☐Yes ☐No	Sickle Cell Disease ☐Yes ☐No
Angina Pectoris ☐Yes ☐No	Dry Mouth ☐Yes ☐No	Human Papillomavirus HPV ☐Yes ☐No	Sinus Problems ☐Yes ☐No
Arthritis ☐Yes ☐No	Emphysema ☐Yes ☐No	Kidney Problems ☐Yes ☐No	Sleep Apnea ☐Yes ☐No
Artificial Heart Valve ☐Yes ☐No	Epilepsy ☐Yes ☐No	Liver Disease ☐Yes ☐No	Stroke ☐Yes ☐No
Artificial Joint ☐Yes ☐No	Fainting Spells/Dizziness ☐Yes ☐No	Lung Disease ☐Yes ☐No	Thyroid Problems ☐Yes ☐No
Asthma ☐Yes ☐No	Fever Blisters ☐Yes ☐No	Mitral Valve Prolapse ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Bacterial Endocarditis ☐Yes ☐No	Glaucoma ☐Yes ☐No	Pacemaker ☐Yes ☐No	Ulcers ☐Yes ☐No
Blood Transfusion ☐Yes ☐No	Heart Attack ☐Yes ☐No	Psychiatric Problems ☐Yes ☐No	Yellow Jaundice ☐Yes ☐No
Cancer– Chemotherapy ☐Yes ☐No	Heart Surgery ☐Yes ☐No	Radiation Therapy ☐Yes ☐No	
Colitis ☐Yes ☐No	☐Yes ☐No	Rheumatic Fever ☐Yes ☐No	

Any serious Illness/ Condition not listed above? ☐Yes ☐No **If yes, please explain:**_____

Patients should discuss any relevant health issues prior to treatment. I certify that I understand the information in this form and the answers I provided are complete, truthful and accurate. I will not hold Keller Dental responsible for any actions taken, or not taken, because of errors or omissions that I may have made in completing this form.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____DATE:_____