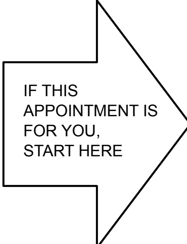
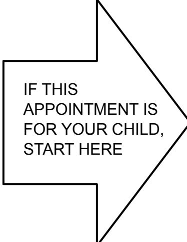
PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



1

DATE			
LAST NAME	FIRST		MI
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE		ZIP
HOME PHONE	FAX		
CELL PHONE	EMAIL		
BIRTHDATE	AGE	GENDER	
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			



DATE			
LAST NAME	FIRST		MI
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE		ZIP
HOME PHONE			
BIRTHDATE	AGE	GENDER	
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX TOO

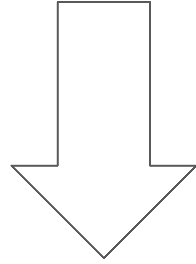
DENTAL INSURANCE 2

PRIMARY CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

SECONDARY CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	



GETTING TO KNOW YOU 3

IS A RELATIVE OF YOURS A PATIENT AT OUR OFFICE?

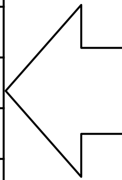
NAME:		
RELATIONSHIP:		

YOU WERE REFERRED TO US BY

NAME:

EMERGENCY CONTACT

NAME:		
CELL NUMBER:		
HOME NUMBER:		
ADDRESS		
CITY	STATE	ZIP



ACCOUNT INFORMATION 4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		

YOU

NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.

YOUR SPOUSE

NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.

Please turn over and sign

Name: ______________________________ Medical Alert: ______________________

1. Physician's Name __________________________ Phone ______________________________
   Have you had any medical care within the past two years? ………………………………………………Y N
   Describe ____
2. Have you taken any medication or drugs during the past two years? ……………………………………Y N
   If yes, please list name and dosage ____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Y N
   If yes, please list name and dosage: ____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? Y N
   If yes, please list name and dosage ____
5. Are you aware of having an allergic (or adverse) reaction to any substance or medication?………………Y N
   If yes, please specify ____
6. Have you been a patient in the hospital during the past five years? ………………………………………Y N
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack) ..	Yes	No	Ulcers ……………	Yes	No	Hepatitis A B C (circle) ...	Yes	No
Chest Pain	Yes	No	Diabetes ……………	Yes	No	Venereal Disease ………..	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S./H.I.V. Positive …	Yes	No
Heart Murmur	Yes	No	Glaucoma …………	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact lenses ……	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema ………	Yes	No	Hemophilia ……………….	Yes	No
Artificial Heart Valve/Pacemaker ..	Yes	No	Chronic Cough …	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis ………	Yes	No	Bruise Easily ……………..	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma …………	Yes	No	Liver Disease/Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity …	Yes	No	Epilepsy or Seizures…..	Yes	No
Stroke	Yes	No	Sinus Trouble …….	Yes	No	Fainting or Dizzy Spells ..	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy ….	Yes	No	Nervous/Anxious ……..	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy …..	Yes	No	Psychiatric/Psychological Care..	Yes	No
Kidney Trouble ……………………	Yes	No	Tumors …………	Yes	No	Cancer	Yes	No

8. Have you lost or gained more than 10 pounds in the past year? ………………………………………….. Y N
9. Do you have or have you had any disease, condition, or problem not listed?…………………………… Y N
   If yes, please list: ____
10. **Women**: Are you pregnant or think you could be pregnant? Yes ___ Months No **Nursing**? Y N
11. Do you use birth control prescriptions?……………………………………………………………..… Y N

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: ______________________________Date: ____________________

History Review: ____

____

Dentist Signature: ____

Name: ________________________________ Medical Alert: ____________________

What is the reason for your visit today? ____

____

Date of Last Dental Visit: ____________ Last Dental Cleaning: ___________ Last FMX: __________

What was done at your last dental visit? ____
Previous Dentist's Name: ________________________________ Phone: ________________
How often do you have dental examinations? ______________________________________
How often do you brush your teeth? ________________How often do you floss? ______________
Have you ever used or are currently using topical fluoride? ________________________________
What other dental aids do you use? (Interplak, toothpick, etc.) ______________________________
Do you have any dental problems now? Yes No If yes, please describe: ____________________

____

Are your teeth sensitive to:

Hot or cold	Yes	No
Sweets	Yes	No
Biting or Chewing	Yes	No
Have you noticed mouth odors	Yes	No
Do you get cold sores/blisters/lesions	Yes	No
Do your gums bleed or hurt	Yes	No
Any family history of gum disease	Yes	No
Any loose teeth or change in bite	Yes	No
Does food get caught between teeth	Yes	No

If yes, where: ________________________

Do you:

Clench/grind either awake or asleep	Yes	No
Bite your lips/cheeks regularly	Yes	No
Hold foreign objects in teeth	Yes	No
Mouth breathe while awake or sleeping	Yes	No
Have tired jaw, especially in morning	Yes	No
Smoke/chew tobacco	Yes	No

Have you ever had:

Orthodontic Treatment	Yes	No
Oral Surgery	Yes	No
Periodontal treatment	Yes	No
Your teeth ground/bite adjustment	Yes	No
A bite plate or mouth guard	Yes	No
Serious injury to the mouth/head	Yes	No

Please describe, include cause ______________

____

Have you experienced:

Clicking/popping of the jaw	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening/closing mouth	Yes	No
Headaches/neck/shoulder aches	Yes	No
Sore Muscles (neck/shoulders)	Yes	No
Snore or have sleeping disorders	Yes	No

Are you satisfied with your teeth's appearance .... Yes No
Would you like to replace your silver fillings... Yes No
Would you like to keep all of your teeth all of your life?.................................... Yes No
Do you feel nervous about having dental treatment?.. Yes No
Please describe ____
Have you ever had an upsetting dental experience .... Yes No
Please describe ____
Have you ever been told to take a pre-medication prior to dental treatment .... Yes No
Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe: ____

____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's Signature: ________________________________ Date: ____________________

Parent/Responsible Party's Signature: ____

Relationship to Patient: ____

The Dental Board of California Dental Materials Fact Sheet

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix title "Comparisons of Restorative Dental Materials." A "Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 – 2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions base upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made.

The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Patient Acknowledgment of receipt of Dental Materials Fact Sheet

I, __________________________ acknowledge that I have read a copy of the Dental Materials Fact sheet dated October 2001.

Patient Signature: _____________________________ Date: ____________________

BRIAN J. HANRATTY, D.D.S.
509 Five Cities Drive
Pismo Beach, Ca 93449
805-773-2l3l

I,--, give

_______________________________’s office permission to release my

records to ---

THANK YOU,

— —

Patients signature DOB Date

Brian Hanratty DDS

Dr. Hanratty and staff have instituted this agreement in order to meet our patient's expectation of the highest quality of care and customer service. Please review this carefully and acknowledge with your signature below.

Co-Payments, Co-Insurance, and Deductibles

-Co-Payments are an estimated amount based on information provided by your insurance company and by you. Co-pays are due and collected on the date of service. We will gladly file your claims, and assist in getting payment from the insurance carrier. However, ultimately all services rendered are the responsibility of the patient and/or guarantor. Insurance carriers change, policies lapse, and numerous other factors beyond our control may alter the actual payment.
We make every effort to research insurance information for you, however patients are ultimately responsible for knowing eligibility, frequency and limitations. Information like this can be found in your handbook or by contacting your plan administrator. Any changes to insurance should be brought to our attention prior to appointments so that we may assist you in filing your claim.

Missed Appointments/Late Cancellations

- Missed appointments and/or appointments canceled less than 24 hours prior to appointment time may incur a $35 fee. Excessive missed appointments may result in discharge from the practice.

Delinquent Accounts

-Patients with delinquent accounts will be required to pay their balance in full prior to making any further appointments. There is a $35.00 charge for any returned checks.

Patient Signature____________________________Date: _________________