McCarthy Dental Group
17 N. Harding Rd. Columbus, OH 43209

PATIENT REGISTRATION

Welcome to our office. We are pleased that you have chosen us to assist you with your dental care. In order to care for you and communicate better, please fill out both sides of this form completely.

①About You

Today's Date: _____
Name: Mr. Mrs. Ms. Dr. _____
(LAST) (FIRST) (MI)
I prefer to be called: _____
Birthdate: _____ Age: _____ S.S.#_____
Home Address: _____
City: _____ State: _____ Zip: _____
❑ Male ❑ Female
Home Phone #: _____ Cell #: _____
Work Phone #: _____ Ext: _____ E-Mail: _____
Where & when are the best times to reach you? _____
Employer: _____
Employer's Address: _____
How long have you worked there? _____ Occupation: _____
Is another family member or relative a patient in our office? _____
Name: _____ Relationship: _____

②About Your Spouse

His/Her Name: _____
Employer: _____ Occupation: _____
Work Phone #: _____ Ext: _____

③Account Information

Person Financially Responsible for Account: _____
Relation to Patient: _____ S.S.#: _____
Billing Address: _____
Work Phone #: _____ Ext: _____ Home Phone #: _____
Employer: _____

④Emergency Contact

In the event of an emergency, whom should we contact?
His/Her Name: _____ Relation: _____
Work Phone #: _____ Cell Phone #: _____

⑤Referral Source

Our practice is fortunate to receive referrals from patients and colleagues who have been pleased with the services that we provide. Whom may we thank for referring you to us?

_____

⑥Dental Benefits

Does your employer provide dental benefits? ❑ Yes ❑ No
Are you eligible for direct reimbursement benefits? ❑ Yes ❑ No
Benefit Co. Name: _____
Benefit Co. Address: _____
Benefit Co. Phone #: _____
Group #: _____
Name of Policy Holder: _____ Relation: _____
Birthdate of Policy Holder: _____ Policy Holder's S.S.#: _____
Policy Holder's Employer: _____ Date Employed: _____

The services that we provide for you are based on an agreement between you and our office. Your dental benefit relationship constitutes an agreement between you, your employer and your benefit carrier. Please carefully review our policy regarding dental benefits and your responsibilities as the policy holder. Our dental team is here to help you and will be happy to answer any questions that you may have.

⑦Financial Responsibility

I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event of default, I promise to pay legal interest (1.5% per month – 18% per annum), together with any collection costs and attorney fees as may be required to effect collection of this note. I also understand that failure to cancel my appointments without 48 hours advance notice will result in a $50 charge.
I hereby authorize payment of my dental benefits directly to McCarthy Dental Group. I understand that my dental care benefit carrier or payor of my dental benefits may pay less than the actual bill for services and I understand that I am financially responsible for payments in full of all accounts by signing this agreement.

_____ Date: _____ Relationship to patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to patient: _____
Signature of guarantor of payment/responsible party

Dental History

Welcome to our office. So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

Previous Dentist: _____ Period of Treatment: _____

Address: _____ Phone Number: _____

Date of last visit: _____ Last full mouth x-rays: _____ Last complete exam: _____

Frequency of dental care: _____ Regular _____ Periodic _____ Emergency

How would you rate your home care? _____ Good _____ Fair _____ Poor

What is your immediate dental concern? _____

_____

Please circle Yes or No. If yes, please fill in details.

YES NO Are you presently experiencing any dental pain or discomfort? _____

YES NO Have you ever had an upsetting dental experience? _____

YES NO Do you feel nervous about receiving dental treatment? _____

YES NO Is any part of your mouth sensitive to temperature, pressure, or food/drink? _____

YES NO Do you have an unpleasant taste or odor in your mouth? _____

YES NO Do your gums hurt or bleed when you brush or floss? _____

YES NO Have you ever been told you have gum disease? _____

YES NO Have you been treated for gum disease? When? _____

YES NO Have your parents experienced gum disease? _____

YES NO Have you lost any teeth? From what cause? _____

YES NO Have you noticed any loose teeth or change in your bite? _____

YES NO Does food catch between your teeth? Where? _____

YES NO Do you have any pain or soreness around your eyes or ears or other parts of your face? _____

YES NO Are you aware of stiff neck muscles? How often? _____

YES NO Do you ever awaken with an awareness of sore teeth or joints? How often? _____

YES NO Are you aware of your jaw clicking or popping while eating or yawning? How often? _____

YES NO Do you have difficulty opening/closing your mouth? _____

YES NO Do you have "tension" headaches? How often? _____

YES NO Have you ever had your bite adjusted? When? _____

YES NO Have you ever worn a bite splint or night guard? When? _____

YES NO Have you ever experienced a serious injury to your head or mouth? _____

YES NO Have you ever had orthodontic treatment? When? _____

YES NO Have you ever had oral surgery? When? _____

YES NO Do you smoke or chew tobacco? _____

YES NO Is your home water supply fluoridated? _____

YES NO Are you dissatisfied with the appearance of your teeth/smile? Why? _____

YES NO Do you think your dental disease is active? _____

YES NO Do you want to learn to control your dental disease to retain your teeth? _____

YES NO Are you deeply concerned about the finances required to return your mouth to excellent health? _____

Why have you chosen our office for your dental care? _____

Medical History

Have you been under the care of a physician during the past two years? ❑ Yes ❑ No
If yes, for what? _____
Physician's name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Are you currently taking any medications, drugs, or pills? ❑ Yes ❑ No
If yes, please list name and dosage _____

_____

Are you aware of having an allergic or adverse reaction to any medication or substance?
❑ Yes ❑ No If yes, please describe _____
Have you been a patient in the hospital during the past 5 years? ❑ Yes ❑ No
Name and phone number of your preferred pharmacy _____

Please indicate which of the following you have had, or have at present. Circle Y for Yes, N for No.

Heart Attack ..... Y N	Diabetes ..... Y N	Radiation Therapy ..... Y N
Heart Surgery ..... Y N	Tuberculosis ..... Y N	Nervous/ Anxious ..... Y N
Chest Pain ..... Y N	Asthma ..... Y N	Artificial Joints (Hip, Knee, etc.) ..... Y N
Congenital Heart Disease..... Y N	Liver Disease ..... Y N	Chemotherapy ..... Y N
Heart Murmur ..... Y N	Arthritis, Rheumatism ..... Y N	Psychiatric/Psychological Care ..... Y N
Mitral Valve Problems ..... Y N	Cortisone Medicine ..... Y N	Kidney Trouble ..... Y N
Artificial Heart Valve ..... Y N	Latex Sensitivity ..... Y N	Tumors ..... Y N
Rheumatic Fever ..... Y N	Neurological Disorders ..... Y N	A.I.D.S. ..... Y N
Heart Pacemaker ..... Y N	Allergies or Hives ..... Y N	H.I.V. Positive ..... Y N
High Blood Pressure ..... Y N	Epilepsy or Seizures ..... Y N	Thyroid Problems ..... Y N
Swollen Ankles ..... Y N	Stroke ..... Y N	Hemophilia ..... Y N
Ulcers ..... Y N	Sinus Trouble ..... Y N	Cold Sores/Fever Blisters ..... Y N
Hepatitis ..... Y N	Fainting or Dizzy Spells ..... Y N	Emphysema ..... Y N

Do you have or have you had any disease, condition, or problem not listed above? ❑Yes ❑No
If yes, describe_____
Have you ever been told that you require premedication with antibiotics prior to dental treatments? ❑ Yes ❑ No
Are you a smoker? ❑ Yes ❑ No
Do you have any allergic skin reactions to metal jewelry? ❑ Yes ❑ No
Women: Are you pregnant? ❑Yes ❑No Nursing? ❑Yes ❑No Taking Birth Control Pills? ❑Yes ❑No
Comments:

Consent for Treatment

I understand that the information contained in the dental and medical histories 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. If further information is needed, you have my permission to ask my respective health care provider or agency who may release such information to you. I will notify McCarthy Dental Group of any changes in my health or medication. The undersigned hereby authorizes McCarthy Dental Group to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize McCarthy Dental Group to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Patient Signature_____ Date_____
Parent/Guardian Signature_____ Date_____