GENERAL PATIENT INFORMATION

Patient Registration

Patient Information

Full Name: ______________________________

Date of Birth: ______________________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Sex: ☐ Male ☐ Female

Social Security Number: ______________________________

Email Address: ______________________________

Home Phone Number: ______________________________

Cell Phone Number: ______________________________

Drivers License

State: ______________________________

Number: ______________________________

Home Address:

Address: ______________________________

City, State and ZIP: ______________________________

Billing Address:

Address: ______________________________

City, State and ZIP: ______________________________

Work Information

Employer: ______________________________

Occupation: ______________________________

Work Phone Number: ______________________________

Method of Contact: ☐ Phone ☐ Email ☐ Either Phone or Email

Emergency Contact:

Full Name: ______________________________

Phone Number: ______________________________

Relation:

How did you hear about our office?

Who may we thank for referring you? ______________________________

GENERAL PATIENT INFORMATION

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name: ______________________________

Social Security: ______________________________

Relation to Patient: ______________________________

Primary Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: ______________________________

Date of Birth: ______________________________

Social Security: ______________________________

Employer: ______________________________

Policy Number: ______________________________

Group Number: ______________________________

Coverage Type: ☐ Individual ☐ Family ☐ Prepaid / Capitation

Insurance Company: ______________________________

Company Phone Number: ______________________________

Company City, State, ZIP: ______________________________

Secondary Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: ______________________________

Date of Birth:

Social Security: ______________________________

Employer: ______________________________

Policy Number: ______________________________

Group Number: ______________________________

Coverage Type: ☐ Individual ☐ Family ☐ Prepaid / Capitation

Insurance Company: ______________________________

Company Phone Number: ______________________________

Company City, State, ZIP: ______________________________

Medicaid Number: ______________________________

I authorize the medical doctor to release any information, including diagnosis, treatment plans/records and radiographs to third party payors and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the medical group or medical benefits that are, otherwise, payable to me. I understand that my medical insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this medical office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature:

Insurance companies we are in network for:

Delta Dental

Cigna

United Healthcare

Metlife

Guardian

Financial Options:

Care Credit

Visa, MasterCard, Discover, and American Express

Keenan D Cave DMD Dental
Indianapolis, IN 46241

Informed Consent
For Oral and Maxillofacial Surgery
Procedures: Surgical removal of tooth/teeth number(s): _______________
Alternatives to Surgery: Risks to my health if the above procedure is not performed include but are not limited to:
Infection;
Cyst or tumor formation;
Periodontal (gum) disease; and
Increased risk for complications if removal is required at a later time.
Possible Complications which have been discussed with me include but are not limited to:
1. Injury to the nerves, to the lower lip, and tongue causing numbness which could be permanent;
2. Bleeding and/or bruising which may be prolonged;
3. Dry socket;
4. Involvement of the sinus above the upper teeth;
5. Infection;
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and increased risk of complications;
7. Injury to adjacent teeth or fillings; and
8. Unusual reaction to medications given or prescribed. Additionally:
9. ____
I understand that a perfect result cannot be guaranteed. If any unforeseen conditions arise during the procedure, I request and authorize the doctor to do whatever he deems advisable to correct the condition.
I agree to cooperate completely with Dr.___________________, and will follow postoperating instructions to the best of my ability for my own comfort and safety. I have had the opportunity to ask questions concerning these procedures.

_______________________________ _________________________

Patient, Parent or Guardian Date

_____________________________ _________________________

Doctor _______________________

Witness_______________________

PATIENT MEDICAL HISTORY

Patient's Medical History

Physician Information

Physician's Full Name: ______________________

City, State and ZIP: ______________________

Are you currently under a physician's Care? ☐ Yes ☐ No

If Yes, for what?

Have you been hospitalized in the last two years? ☐ Yes ☐ No

If Yes, for what?

Are you taking any medication, drugs or pills? ☐ Yes ☐ No

If so, please list the names and dosages of each:

Do you Smoke? ☐ Yes ☐ No How Much? ______________________

Women Only

Are you pregnant? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No Are you on Hormone Therapy? ☐ Yes ☐ No

Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

Medical Alerts

☐ Allergic to Penicillin
☐ Allergic to Tetracycline
☐ Allergic to Aspirin
☐ Allergic to Codeine
☐ Allergic to 'Novocaine'
☐ Allergic to Latex Rubber
☐ Pre-Medication required
☐ Mitral Valve Prolaspe
☐ Heart Problems
☐ Pacemaker
☐ HIV Positive
☐ Prior Hepatitis

☐ Other ______________________

____

Medical Conditions

☐ Heart Attack
☐ Heart Murmur
☐ Chest Pain
☐ Congenital Heart Problem
☐ Artificial Heart Valve
☐ Heart Surgery
☐ High/Low Blood Pressure
☐ Rheumatic Fever
☐ Anemia
☐ Blood Disease
☐ Blood Transfusion
☐ Stroke
☐ Deep Vein Clot
☐ Hemophilia
☐ Excessive Bleeding when Cut
☐ Sickle Cell Disease
☐ Glaucoma
☐ Diabetes
☐ Excessive Thirst
☐ Scarlet Fever
☐ Thyroid Disease
☐ Parathyroid Disease
☐ Kidney Disease
☐ Liver Disease
☐ Hepatitis A or B
☐ Yellow Jaundice
☐ Cancer
☐ X-Ray or Cobalt Treatment
☐ Chemotherapy
☐ Ulcers
☐ Gastrointestinal Upset
☐ Acid Reflux
☐ Lung Disease
☐ Tuberculosis
☐ Shortness of Breath
☐ Emphysema
☐ Asthma
☐ Sinus Trouble
☐ Hay Fever
☐ Frequent Cough
☐ Rheumatism
☐ Arthritis/Gout
☐ Swelling of Feet/Ankles
☐ Artificial Joint Replacement
☐ Psychiatric Care
☐ Epilepsy or Seizures
☐ Extreme Nervousness
☐ Fainting or Dizziness
☐ Hypoglycemia
☐ Hives
☐ Cold Sores/Fever Blisters
☐ Venereal Disease
☐ Herpes
☐ Cortisone Treatment
☐ Chemical Dependency

PATIENT DENTAL HISTORY

Patient's Dental History

What is your primary reason for seeking dental care?

____

Previous Dentist Information

Dentist's Full Name: ______________________________

City, State and ZIP: ______________________________

Month and Year of Last Visit: ______________________________

What was done at your last visit? ______________________________

Date of Last full mouth x-rays: ______________________________

Reason for leaving previous dentist: ______________________________

How often do you visit the dentist? ☐ Annual Check Up ☐ Twice a Year Check Up ☐ Only when I have a problem ☐ Other

Please choose the appropriate answer

Are you nervous about receiving dental treatment? ☐ Yes ☐ No

Do you gag easily? ☐ Yes ☐ No

Have you had previous problems with dental care? ☐ Yes ☐ No

If so, please explain?

Are your teeth sensitive to hot, cold, pressure or sweets? ☐ Yes ☐ No

Do you have problems with teeth/fillings breaking? ☐ Yes ☐ No

Are you aware of an uncomfortable bite? ☐ Yes ☐ No

Do your gums feel tender and/or bleed? ☐ Yes ☐ No

Does food catch between your teeth? ☐ Yes ☐ No

Have you had periodontal (gum) treatments? ☐ Yes ☐ No

Do you get sores in or around your mouth? ☐ Yes ☐ No

Do you have regular headaches, earaches or neck pains? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you hear a "clicking" sound when you open/close your mouth? ☐ Yes ☐ No

Does your jaw ever get "stuck?" ☐ Yes ☐ No

Do you have a Temporomandibular (TMJ) jaw disorder? ☐ Yes ☐ No

Are you missing teeth that have not been replaced? ☐ Yes ☐ No

Have you had excessive bleeding after an extraction? ☐ Yes ☐ No

Have you had mouth sores that take long to heal? ☐ Yes ☐ No

Do you have any dental implants? ☐ Yes ☐ No

Do you wear dentures (partials or full)? ☐ Yes ☐ No

Do you have any crowns (caps) or bridges? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you chew tobacco? ☐ Yes ☐ No

Do you have a dry mouth? ☐ Yes ☐ No

Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No

Would you like your smile to look better? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Do you regularly use dental floss? ☐ Yes ☐ No

Do you brush at least once daily? ☐ Yes ☐ No

Is there anything else that you would like us to know?

____

I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site. ☐ Yes ☐ No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: ______________________________