Southgate Dental Care
Comfortable, Personalized Care

ADULT REGISTRATION

NAME:_____DOB:_____SS#_____

ADDRESS:_____ CITY:_____STATE:_____ZIP:_____

HOW LONG?_____HOME PHONE: _____CELL PHONE:_____E-MAIL:_____

EMPLOYER:_____ADDRESS:_____ZIP:_____

OCCUPATION:_____

MARITAL STATUS: MARRIED_____ SINGLE _____ SEPARATED/DIVORCED _____

SPOUSE'S NAME:_____DOB: _____SS#_____

SPOUSE'S EMPLOYER: _____PHONE#_____

IF IT IS NECESSARY TO REACH YOU, WHO CAN WE CONTACT BESIDE SPOUSE?

NAME: _____PHONE#_____

ARE YOU OR SPOUSE A MEMBER OF A DENTAL INSURANCE PLAN? YES_____NO_____

IF YES, PLEASE ANSWER THE FOLLOWING:

EMPLOYEE COVERED:_____NAME OF PLAN_____

GROUP #_____SS#/ID#_____ PHONE #_____

How did you hear about us? (Circle) Web Site, Insurance Plan, Family/Friend_____ Other_____

RELEASE OF INFORMATION

PATIENT(S) NAME_____

I authorize release of information relative to dental treatment received in the office of Mark F. Eisenberg D.D.S., & Associates P.A.

SIGNED: (Parent/Patient)_____DATE:_____

ASSIGNMENT OF BENEFITS

I hereby authorize payment of group dental benefits, otherwise payable, to me, to the named provided for professional services rendered.
I understand that I am responsible for all costs of dental treatment.

SIGNED: (Parent/Patient) _____DATE:_____

STATEMENT OF RESPONSIBILITY

In consideration of the services rendered by the offices of Mark F. Eisenberg, D.D.S.,& Associates, P.A., the undersigned agrees to pay all bills rendered by that office and to be primarily responsible for same.
Delinquent accounts are subject to one and one-half percent (1.5%) per month late charges or $8.00 billing charge on the unpaid balance, plus all reasonable collection charges which shall include but not limited to, all reasonable Attorney's fees, suit fees, agency fees, court costs and Private Process Service expense incurred as a result of the failure to pay the aforementioned bills rendered. The undersigned further hereby waives any claims under the Statute of Limitations and acknowledges receipt of a copy of the statement of responsibility.

_____ _____

WITNESS **SIGNATURE**

DATE:_____

Southgate Dental Care

ADULT MEDICAL HISTORY Date: _____

Name: _____ Age: _____

Physician: _____Office Phone: _____

Approximate date of last physical examination: _____

Are you under any medical treatment now or in the recent past? ..... Yes_____ No_____

Have you had any major operations? If yes, briefly describe:_____

Please circle if you are allergic or are made sick by any of the following: ***Penicillin, Tetracycline, Aspirin, Ibuprofen, Tylenol, Codeine, Local Anesthetic, Fluoride, Metal Jewelry, Latex Products.***

Please list any other allergies: _____

Please list any medicine or supplements taken during the past two years:

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Check any of the following that you have had or have at present:

❑ Heart Disease or Murmur	❑ Blood Disease	❑ HIV Virus or AIDS
❑ High Blood Pressure	❑ Kidney Disease	❑ Hepatitis A (Infectious)
❑ Rheumatic Fever	❑ Liver Disease	❑ Hepatitis B (Serum) or C
❑ Mitral Valve Prolapse	❑ Stomach Ulcers	❑ Yellow Jaundice
❑ Artificial Joint	❑ Venereal Disease	❑ Blood Transfusion
❑ Diabetes	❑ Sinus Trouble	❑ Drug Addiction, Alcoholism
❑ Respiratory Disease	❑ Asthma	❑ Arthritis
❑ Tuberculosis	❑ Cortisone Medicine	❑ Tumors or Growths
❑ Stroke	❑ Cold Sores	❑ Epilepsy or Fainting Spells
❑ Thyroid Disease	❑ Bruise Easily	❑ Psychiatric Treatment
❑ Cancer	❑ Radiation Treatment	❑ Frequent Headaches
❑ Glaucoma	❑ Chemotherapy	❑ Use tobacco products

	Yes	No
When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath?	_____	_____
Are you in good health at this time?	_____	_____
Women: Are you pregnant?	_____	_____
Are you on birth control pills?	_____	_____
Do you anticipate becoming pregnant?	_____	_____
Do you take medication for osteoporosis (Fosamax, Boniva, etc.)?	_____	_____

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ADULT DENTAL HISTORY

Name:_____ Date:_____

What is the reason for your visit today?_____

When was your last routine dental check-up or cleaning?_____

When was your last full set of dental X-Rays?_____

Have you had a dental visit since your last routine dental check-up? Yes____ No____

If yes, please describe reason:_____

Check any of the following that apply to you:

❑ Difficulty opening mouth	❑ Wear a night guard	❑ Mouth breather
❑ Jaw cracks or pops when opening	❑ Teeth sensitive to hot/cold	❑ Frequent cold sores or mouth lesions
❑ Pain in ears	❑ Teeth sensitive to sweets	❑ Had braces or bite adjustment
❑ Clenching/grinding teeth	❑ Teeth sensitive to biting	❑ Had teeth bleaching
❑ Frequent headaches	❑ Broken/chipped teeth	❑ Dry mouth
❑ Frequent snoring	❑ Gums bleed	❑ Tumors or Growths in mouth
❑ Bad reaction to numbing	❑ Bad taste/breath	❑ Use tobacco products
❑ Prolonged bleeding after extraction	❑ Loose teeth/shift in bite	❑ Food often gets caught between teeth
❑ Difficult past extraction	❑ Previous gum treatment	❑ Chew only on one side
❑ Difficulty getting numb	❑ Parents with gum disease	❑ Nervous about dental visits

Do you have any dental complaints? If yes, please describe:_____

When you look at your smile in the mirror, do you see a defect in any of your teeth that bothers you? If yes, please describe:

_____

Would you like whiter teeth?_____

Is there anything else about having dental treatment that you would like us to know?_____

_____

I have answered the above questions about my medical and dental history accurately and to the best of my knowledge.

Signature_____ Date_____

Doctor's Signature_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____