Varner
Family Dentistry

Patient Registration **(section must be completed yearly)**

So that we can provide you with the best possible care, please answer all questions. Your answers are for our records only and will be considered confidential.

Doctor's Review:

First Name: Middle: Last Name:

What name do you prefer to go by? Date of Birth:

Address: Street City, State, Zip:

Email: Social Security #: – –

Home Phone: ( ) Cell Phone: ( ) Leave Message? ☐ Yes ☐ No

Employer/School & Grade: Phone: ( ) Leave Message? ☐ Yes ☐ No

Emergency Contact: Relationship: Phone: ( ) Leave Message? ☐ Yes ☐ No

Address: Street City, State: Zip

How did you hear about our office? (Person , Postcard, Internet, Yellow Pages, etc)

What is the reason for your today's visit?

What are your goals for your dental care?

☐ I would like to keep my teeth all my life
☐ I would like to improve the appearance of my smile.
☐ I would like to eat and drink comfortably.
☐ Other

Authorization for Use or Disclosure of Patient Information **(If you want information released to another person other than yourself or parent / guardian.)**

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

☐ X-rays ☐ Treatment Plans ☐ Financial Information ☐ Other_____
☐ Appointments ☐ Medical Problems ☐ All dental / medical information

I authorize the following person(s) to make this use or disclosure:

Name: Phone: ( )

Name: Phone: ( )

Authorization expires on the following date, or when the following event occurs:

Date: Other:

I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that my revocation must be in writing and received by the dental practice's Privacy Official at 3612 W. Southern Hills Blvd. Suite #1, Rogers, AR 72758.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Patient / Guardian Signature: Date:

Primary Dental Insurance

Insurance Company: Phone: ( )

Address: Street City, State, Zip

Subscriber/policy holder: Date Relationship to patient:

of Birth: Social Security #: – –

Employer: Effective Date:

Group #: Identification#:

Reviewed ____|____|____

Varner Family Dentistry

Patient Registration **(section must be completed yearly)**

So that we can provide you with the best possible care, please answer all questions. Your answers are for our records only and will be considered confidential.

Doctor's Review: (continue)

Secondary Dental Insurance (if necessary)

Insurance Company: Phone: ( )

Address: Street City, State Zip

Subscriber/policy holder: Relationship to patient:

Date of Birth: Social Security #: – –

Employer: Effective Date:

Group #: Identification#:

Authorization to Accompany Minor Child for Dental Treatment (section must be completed)

The Federal Government has mandated that Dentists and Clinics must protect the private health information of patients. Varner Family Dentistry realizes that sometimes parents or legal guardians cannot accompany their child to a dental appointment. The purpose of this form is to allow someone other than the parent or legal guardian to accompany a child being treated at Varner Family Dentistry. It must be understood that private health information may be disclosed during treatment.

By my signature below, I hereby authorize the listed individual(s) to accompany my child, in my absence, for treatment at Varner Family Dentistry. Furthermore, I understand that private health information about my child may be disclosed to these individual(s) during treatment.

Name: Age: Relationship:

Name: Age: Relationship:

Name: Age: Relationship:

Name: Age: Relationship:

This authorization may be amended or revoked at anytime by giving written notice.

Parent / Guardian Responsible for Account (if minor-child)

Full Name: Relationship:

Address: Street *City, State & Zip* Home Phone: ( ) Leave Message? ☐ Yes ☐ No

Date of Birth Social Security: – –

Employer: Years at Employer:

Employer Address: Work Phone: ( )

Release

I authorize the doctor or other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care.
I authorize release of any information concerning my (or my child's) health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits
I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members.
I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature

Insurance Authorization Statement:
I hereby authorize payment directly to the Dental Office for the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on the patient registration and the medical & dental histories is correct to the best of my knowledge.

Patient / Guardian Signature: Date:

Patient / Guardian Signature: Updated:

Reviewed ____|____|____

Varner
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Medical History **(section must be completed yearly)**

So that we can provide you with the best possible care, please answer all questions. Your answers are for our records only and will be considered confidential.

Doctor's Review: (continue)

Primary Physician: Name Address Phone ( )

Secondary Physician: Name Address Phone ( )

Last Medical Examination: Day / Month / Year Reason:

Are you currently being treated for any conditions? If so, please list below:

Please list all prescription and non-prescription medications you are taking, including dosage:

Medication Dosage Medication Dosage

Medication Dosage Medication Dosage

Have you ever been hospitalized or had a serious illness? If yes, please explain: ☐ Yes ☐ No

Do you take antacids? ☐ Yes ☐ No Do you take Tagamet or Cimetidine? ☐ Yes ☐ No

Do you take herbal medications or dietary supplements? ☐ Yes ☐ No

☐ Garlic ☐ Ginger ☐ Ma Huang ☐ Kava ☐ Ginko
☐ Ginseng ☐ Ephedra ☐ St. John's Wort ☐ Valerian ☐ Other

Do you consume alcoholic beverages or coffee? ☐ Yes ☐ No
If yes, how frequent?

Do you smoke, use tobacco products? ☐ Yes ☐ No
If yes, how frequent?

Have you ever been told to take antibiotics prior to dental visits? ☐ Yes ☐ No
Do you have a pacemaker or a prosthetic heart valve? ☐ Yes ☐ No
Women: Is there any chance you are pregnant? ☐ Yes ☐ No If yes, how many weeks?
Are you: ☐ Nursing ☐ Taking Birth Control

Are you allergic or sensitive to: ☐ None

☐ Aspirin ☐ Dental Anesthetics (Shots) ☐ Penicillin
☐ Antibiotics ☐ General Anesthetics ☐ Sedatives or Sleeping pills
☐ Base Metals (costume jewelry) ☐ Ibuprofen (Motrin, Nuprin) ☐ Other
☐ Codeine/Other Narcotics ☐ Latex ☐ Other

Have you ever had: ☐ None

☐ Autoimmune ☐ Colitis/Crohn's ☐ Heart Valve ☐ Pace Maker
☐ Abnormal Bleeding/Hemophilia ☐ Congenital Heart Defect ☐ Heart Attack ☐ Psychiatric Problems
☐ Alcohol Abuse ☐ Diabetes ☐ Heart Murmur ☐ Radiation Therapy
☐ Allergies ☐ Difficulty Breathing ☐ Heart Surgery ☐ Rheumatic Fever
☐ Anemia ☐ Drug Abuse ☐ Hepatitis A B C ☐ Sexually Transmitted Disease
☐ Angina Pectoris ☐ Epilepsy/Seizures ☐ High/Low Blood Pressure ☐ Shingles
☐ Arthritis ☐ Facial Surgery ☐ Joint Replacement ☐ Sickle Cell Disease
☐ Asthma ☐ Fainting or Dizziness Fever ☐ Kidney/Bladder Problems ☐ Sinus Problems
☐ Blood Transfusion ☐ Blisters/Canker sores ☐ Liver Disease ☐ Stroke
☐ Cancer ☐ Frequent Headaches ☐ Lung Disease ☐ Thyroid Problems
☐ Chemotherapy ☐ Glaucoma/Cataract ☐ Measles ☐ Tuberculosis
☐ Chest Pain ☐ HIV/Aids ☐ Mitral Valve Prolapse ☐ Ulcers
☐ Other

Reviewed ____|____|____

Varner
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Dental History **(section must be completed yearly)**

So that we can provide you with the best possible care, please answer all questions. Your answers are for our records only and will be considered confidential.

Doctor's Review: (continue)

Who was your previous dentist? Why did you leave?

What did you like most about your last dentist?

Do you have any dental concerns?

Are any of your teeth currently sensitive? If yes, are they sensitive to: ☐ Yes ☐ No ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure

Have you ever had a problem with: ☐ Frequent Decay ☐ Broken Fillings ☐ Fractured Teeth

Have you noticed any mouth odors or unpleasant tastes? ☐ Yes ☐ No

Do your gums hurt or bleed? ☐ Yes ☐ No

Have you noticed any loose teeth or a change in your bite? ☐ Yes ☐ No

Do you have a problem with food impacting between your teeth? ☐ Yes ☐ No

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

Do you have a history of thumb, finger or lip sucking? ☐ Yes ☐ No

Do you have a tongue thrusting habit? ☐ Yes ☐ No

Have you ever experienced:

Clicking or popping of the Jaw? ☐ Yes ☐ No

Difficulty opening or closing your Jaw? ☐ Yes ☐ No

Difficulty chewing? ☐ Yes ☐ No

Pain or soreness around your joint or ear ☐ Yes ☐ No

area? Chronic headaches or facial pain? ☐ Yes ☐ No

Wake up with tired, hurt or ache in your jaw? ☐ Yes ☐ No

Have you ever had an injury or impact to your mouth, jaw or head? ☐ Yes ☐ No

If yes, when and how?

Do you have any missing teeth? ☐ Yes ☐ No

Ifyes, have they been replaced? ☐ Yes ☐ No

If yes, by what means?

☐ Fixed Bridge ☐ Removable Partial ☐ Full Denture ☐ Implant

Are you satisfied with your tooth replacement? ☐ Yes ☐ No

Have you ever had any of the following:

☐ Orthodontic Treatment ☐ Bite Adjustment ☐ Root Canal Treatment ☐ Night Guard

☐ Oral Surgery ☐ Periodontal (gum)Treatment ☐ TMJ Treatment

Have you ever had a problem associated with previous dental treatment?If yes, please explain: ☐ Yes ☐ No

Reviewed ____|____|____