ACHARYA
PERIODONTICS & DENTAL IMPLANTS

Patient Registration Form

Patient Information

Name: _____ Gender: _____
(First) (Last)

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone:_____Mobile: _____Work Phone: _____

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Minor ____ Student ____

Spouse or Parent/Guardian Name: _____ Phone Number: _____

Social Security Number: _____-_____-_____ Date of Birth: _____

Patient or Parent's Employer: _____

Person to Contact In Case of Emergency: _____

Relationship to Patient: _____ Phone Number: _____

Whom May We Thank for Referring You? _____

Insurance Information

Insurance Company: _____ Policy/ID #: _____

Named of Insured: _____ Relationship to Patient: _____

Insured Birthdate: _____ SSN for Insured: _____

Name of Employer: _____ Employer Phone #: _____

Dental History

Name of General Dentist: _____ Date of Last Visit: _____

May We Request Your Dental Records: _____ Purpose of Today's Visit: _____

Have You Been Diagnosed With Periodontal Disease: _____ If yes, When: _____

Did You Receive Periodontal Treatment: _____ If yes, Where: _____

Do You Wear Dentures or Partials: _____ Do You Have Dental Implants: _____

Have You Had Orthodontic Treatment: _____ Do You Clinch/Grind Your Teeth: _____

Medical History

Physician's Name: _____ Phone: _____

Pharmacy Preference: _____ Phone: _____

Are You Required to Take Pre-Medication Prior Dental Treatment: _____

Are You Currently Taking Any Medications: _____ If so, please list: _____

_____

Do You Have Any Allergies: _____ If so, please list: _____

_____

Please Check All That Apply:

- Acid Reflux
- AIDS/HIV
- Allergies
- Anemia
- Asthma
- Arthritis
- Artificial Joint
- Bisphosphonates Use
- Blood Thinner
- Blood Disease
- Cancer
- Cardiac Pacemaker
- Chemotherapy
- Currently Pregnant
- Diabetes I, II
- Emphysema
- Epilepsy
- Glaucoma/Cataracts
- Heart Attack
- Heart Disease
- Heart Murmur
- Heart Surgery
- Hepatitis A, B, C or D
- High Blood Pressure
- Hypoglycemia
- Kidney Disease
- Latex Allergy
- Liver Disease
- Low Blood Pressure
- Migraine Headaches
- Mitral Valve Prolapse
- Neurological Disorder
- Organ Transplant
- Psychiatric Treatment
- Prostate Problems
- Respiratory Problems
- Rheumatic Fever
- Sinusitis
- Stroke
- Substance Abuse
- Swollen Ankles
- Thyroid Disease
- Tobacco Use
- Tuberculosis
- Ulcers

Authorization

I certify that I have read, and I understand the questions above. I acknowledge that my questions, if any, about any of the inquires above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff responsible for any errors or omissions on this form. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. To best service my account, I understand that I may be contacted at any telephone number associated with my account, including wireless numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automatic dialing device, as applicable.

Patient Signature (parent/guardian if minor): _____ Date: _____