PRIME DENTAL CARE - USA
New Patient Registration Form

PLEASE TYPE CLEARLY WITH DARK INK

Patient Information:

Patient Name: _____

Birth Date: _____ Age: _____ Male____ Female ____

State ID or Driver License_____ State:_____ SS#_____

Home Address: _____City/State/Zip: _____

Phone: _____ Cell Phone #:_____

Employer: _____

Email address:_____@_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated

How did you hear about our office? _____

Emergency Contact Person: _____ Phone :_____

**Please provide our receptionist with a Valid Phot ID (State ID or Diver License or Passport) and your current Insurance Card.

Responsible Party Information: (If *NOT* the patient please complete)

Parent or Spouse Name: (circle one) _____
Address: (if different from above) _____
Phone #:_____ Cell Phone #:_____ Is this person currently a patient? Y or N
Birth Date: _____SS#_____
Employer: _____ Work Phone: _____

Insurance Information: (If *OTHER THAN* patient or responsible party please complete below)

Please Present office with your insurance card.

Primary Subscriber Policy Holder Name: _____SS#:_____
Patient Relation to Primary Subscriber _____Self _____Spouse_____Child_____Other:_____
Primary Policy Holder Birth Date: _____Phone: _____
Insurance Company Name :_____ Insurance Type : ____PPO_____DHMO
Primary Policy Holder Insurance #_____ Group Name or Number_____
Insurance Company Provider Phone #_____(on the back of your ins card)
Employer: _____ Work Phone #:_____

Dental Insurance Assignment of Benefits Authorization and Release

PRIME DENTAL CARE USA will gladly assist you in verifying, filing, billing and collecting your insurance claim, but we are unable to accept responsibility for denied claim if there is a dispute. It is your responsibility to pay for the entire amount not covered by your dental benefit plan. By signing this form, you hereby assign all payments for services provided for yourself or dependents to PRIME DENTAL CARE USA.

All accounts 30 days and over are PAST DUE and subject to interest. All balances 90 days past due may be turned over for collection. In the event, you or your insurance company fail to pay and it is necessary to employ outside collections efforts, you are responsible for reasonable costs for collection, including but not limited to court costs, attorney fees and collection agency fees.

_____

Responsible Party's Signature Date

By signing below, I certify that I have completed the above information to the best of my knowledge.

_____

Name of Patient or Parent **Signature of Patient or Parent** **Date**

PLEASE TYPE CLEARLY WITH DARK INK

Patient Medical History:

Physician's Name: _____ Phone #:_____ Date of last visit:_____

1. Are you under medical treatment now? Yes No

2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No

3. Are you taking any medication(s), including non-prescription medications or diet pills? Yes No
Please List:_____
_____
_____(use separate sheet if needed)

4. Do you use alcohol? Yes No

5. Do you use Tobacco? Yes No

6. Are you taking any type of Blood thinners or Blood altering Medications: anti-platelets or anti-coagulants? Yes No
List:_____

7. Are you allergic to or have any reactions to the following?

Local Anesthetics (e.g. Lidocaine)	Yes	No
Penicillin or other Antibiotics	Yes	No
Latex	Yes	No
Narcotic Drugs (e.g. Percodan)	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Aspirin	Yes	No
Metal _____	Yes	No

Other Allergen not listed above_____

8. Women Only:
Are you pregnant or think you may be pregnant Yes No
Are you nursing? Yes No
Are you taking birth control Yes No
List:_____

9. Are you taking any type of bisphosphonates or any other Bone dentistry Altering medication? Yes No
If Yes, List Name :_____Frequency _____Since _____

10. Are you taking any Immunosuppressive Medication? Yes No
If Yes, List Name :_____Frequency _____Since _____

11. Are you taking any type of Hormone Replacement medications? Yes No
If Yes, List Name :_____Frequency _____Since _____

12. Do you have or have you had any of the following? (Explain below)

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack or Surgery	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Hay Fever/Allergies	☐	☐	Angina	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Respiratory Problems	☐	☐	Radiation Therapy	☐	☐	Anemia	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Recent Weight Loss/Gain	☐	☐	Cancer	☐	☐
Artificial Heart Valve	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Mitral valve Prolapse	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Asthma	☐	☐
AIDS/HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Diabetes	☐	☐
Thyroid Problems	☐	☐	Stomach Problems/Ulcers	☐	☐	Leukemia	☐	☐
Artificial Joints	☐	☐	Osteoporosis (Bone weakness)	☐	☐	Bone Problems	☐	☐

Other Problems: _____
Explanation: _____

Patient Dental History:

How long since your last Dental Visit: _____ Cleaning: _____ X-rays:_____

1. Do your gums bleed while brushing or flossing ? Yes No
2. Are your teeth sensitive to hot or cold foods/liquids? Yes No
3. Are your teeth sensitive to sweet or sour foods/liquids? Yes No
4. Do you have any sores or lumps in or near your mouth? Yes No
5. Have you had any head or neck injuries? Yes No
6. Have you ever experienced any of the following problems in your jaw? Pain (joint, ear, side of face) Difficulty in opening or closing Difficulty in chewing
7. Do you have frequent headaches? Yes No
8. Do you clench or grind your teeth? Yes No
9. Have you ever had any difficult extractions? Yes No
10. Did you wear braces? Yes No
11. Have you had prolonged bleeding following dental extraction? Yes No
12. Have you ever had instruction on brushing or flossing? Yes No

By signing below, I certify that I have completed the above information to the best of my knowledge.

Name **Signature** **Date**_____

Doctor Signature _____