NeetaSomani
All good things in Life begin with a Smile

REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle:

Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐ | Birth date: | Sex: ☐ M ☐ F

If full-time student, School name: Grade:

Street address: | Social Security no.: | Home phone no.: ( ) | Cell phone no.: ( )

P.O. box/APT#: | City: | State: | ZIP Code: | E-mail: Would you like to receive e-mails from us? ☐

Occupation: | Employer: | Employer phone no.: ( )

How did you hear about us? (Please check one box): | Referred by: ☐ Insurance plan ☐ Flyer

☐ Postcard ☐ E-mail ☐ Close to home/work ☐ Yellow Pages ☐ Coupon ☐ Other _______________

Has any other member of your family been to this office? ☐ Yes ☐ No If Yes, name:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

PRIMARY INSURANCE	SECONDARY INSURANCE (IF APPLICABLE): In case of minor child, enter second parent info here
Person responsible for bill: / Birth date:	Person responsible for bill: / Birth date:
Address (if different):	Address (if different):
Is this person a patient here? ☐ Yes ☐ No	Is this person a patient here? ☐ Yes ☐ No
Phone: / Employer:	Phone: / Employer:
Dental Insurance Co.:	Dental Insurance Co.:
Subscriber # / Group # / SS#	Subscriber # / Group # / SS#
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

METHOD OF PAYMENT

Payment in full at end of appointment by ☐ Cash ☐ Check ☐ Visa ☐ MC ☐ Amex ☐ Discover | I wish to obtain special financing options:

Card #: Exp: | APFUSA ☐ CareCredit ☐

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The above information and the medical/dental history is true to the best of my knowledge. I also authorize the dentist to release my dental/medical histories and any other information about my dental treatment to third party payors and/or other health professionals.

Patient/Guardian signature *State Driver's License #* *Date*

PATIENT NAME ______________________________ **DATE** ______________

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe ______	Yes No
Do you have dental examinations on a routine basis? Last visit ______	Yes No
Do you think you have active decay or gum disease? ______	Yes No
Do you brush and floss on a routine basis? Discuss ______	Yes No
Do your gums ever bleed? Discuss ______	Yes No
Do you like your smile? Why? ______	Yes No
Does food catch between your teeth? Any loose teeth? ______	Yes No
Do you want to keep your remaining teeth? ______	Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ______	Yes No
Have your past experiences in a dental office always been positive? ______	Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss ______	Yes No

Name of previous dentist (optional): ______

Date of last full mouth x-rays (16 small films or panoramic): ______

Medical History

Are you under a physician's care now? Why? ______ Who? ______ Phone ______	Yes No
Have you ever been hospitalized or had a major operation? Discuss ______	Yes No
Have you ever had a serious injury to your head or neck? Discuss ______	Yes No
Are you taking any medications, pills or drugs? What? ______ Ever taken fen-phen?* ______	Yes No
Are you on a special diet? Discuss ______	Yes No
Are you allergic to any medications or substances? Please check box below ______	Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other ______

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss ______ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Cold Sores	☐	☐
Heart Murmur *	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Thyroid Disease	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Breathing Problem	☐	☐	Diabetes	☐	☐	Artificial Joint *	☐	☐	Nervousness	☐	☐
Heart Pace Maker *	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐
Heart Surgery	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A (Infectious)	☐	☐	Genital Herpes	☐	☐	Allergies (Pollen / Dust)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B or C	☐	☐	Drug Addiction/Alcoholism	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Bloody Sputum	☐	☐	Night Sweats	☐	☐	Tattoos	☐	☐	Need Premedication?	☐	☐

Have you ever had any other serious illness not checked above? Discuss ______	Yes No
Do you wish to talk to the dentist privately about any problem? ______	Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X ______________________________ Date ______________

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor ______________ Date ______________ BP ______

History Review and Significant Findings ______________________________

Medical Updates

I have read my MEDICAL HISTORY dated ______________ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
		None ☐			Dr.
		None ☐			Dr.
		None ☐			Dr.
		None ☐			Dr.
		None ☐			Dr.
		None ☐			Dr.
		None ☐			Dr.

The Dental Board of California
Dental Materials Fact Sheet
(http://www.dbc.ca.gov/pdf/dmfs2004.pdf)

On May 14, 2004, the Board updated the Dental Materials Fact Sheet.
Business & Professions Code section 1648.15, and it requires the following:

- ✓ The dentist must provide this updated fact sheet to every new patient and to patients of record before performing dental restoration work.
- ✓ The dentist needs to provide the fact sheet to each patient only once.
- ✓ The patient must sign an acknowledgment of receipt of the fact sheet and a copy of the acknowledgment must be placed in the patient's dental record.
- ✓ If the Board updates the fact sheet, the updated fact sheet must be given to patients in this same way.
- ✓ The dentist must also provide the fact sheet to the patient upon request.
- ✓ This requirement shall not apply to any surgical, endodontic, periodontic, or orthodontic dental procedure in which dental restorative materials are not used.

"Patient Release Form":

I, ______________________, have received from Dr. Neeta Somani, DDS, Inc. a copy of the Dental Materials Fact Sheet as required by law.

____ ______________

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

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 acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

□ Individual refused to sign
□ Other (pleas specify)
____
____

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