Advanced Dentistry of Blue Ash
Patient Registration

Date _____

Patient Name _____ Birthdate _____ Age_____
First Middle Last
SS#_____DL#_____ Occupation _____Work # (___) _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Name of Spouse _____ Work # (___) _____

Home Address_____ Zip _____

Home Number# (____) _____Cell Phone # (___) _____ Preferred Contact# (__) _____

E- Mail Address _____

Employer Name and Address _____

Person Responsible for Account_____Relationship to patient_____

Social Security # _____DL#_____Home # (___)_____

Home Address (if different)_____State_____Zip_____

Employer & Address_____State_____Zip_____

Occupation_____Work # (___) _____

Who referred you to our practice? _____

Do you have Dental Insurance? ❑ Yes ❑ No With Whom?_____

Nearest Relative Not Living With You?_____Relationship_____

Address_____State_____Zip_____Phone_____

What are your concerns? *Mark all that apply:* ❑ Routine Checkup ❑ Cleaning ❑ General Health ❑ Appearance
❑ Pain Avoidance ❑ Cavities ❑ Losing Teeth ❑ Oral Cancer
❑ Gum/Periodontal Disease ❑ Wasting/Exceeding Dental Insurance Limits

Are you currently having any dental problems/concerns? _____

Medical

1. Have there been any changes in your health since your last visit? ❑ Yes ❑ No
   If yes explain: _____
2. Are you currently under the care of a physician? ❑ Yes ❑ No
   Physician's Name:_____ Reason:_____
3. Are you taking any medications? ❑ Yes ❑ No Please list medications:_____

_____

4. Are you allergic to any of the following: ❑ **Penicillin** ❑ **Latex** ❑ **Sulfur** ❑ **Codeine**
   ❑ **Novocain** ❑ **Other:**_____

5. Has your physician ever informed you that you have or had any of the following:

❑ **Heart Ailment / Disease**	❑ **Rheumatic Fever**	❑ **Stroke**	❑ **Psychiatric Treatment**
❑ **Mitral Valve Prolapse**	❑ **Blood Disease**	❑ **Liver Disease**	❑ **Are You Pregnant**
❑ **High / Low Blood Pressure**	❑ **Kidney Disease**	❑ **Diabetes**	❑ **Hepatitis**
❑ **Respiratory Disease**	❑ **Tumors or Growths**	❑ **Glaucoma**	❑ **Venereal Disease**
❑ **Stomach / Intestinal Disease**	❑ **Epilepsy / Convulsions**	❑ **Tuberculosis**	❑ **Syphilis**
❑ **Thyroid Trouble / Goiter**	❑ **Abnormal Bleeding**	❑ **Eczema / Hives**	❑ **HIV+ / AIDS**
❑ **Anemia / Leukemia / Low Platelets**	❑ **Prostate Trouble**	❑ **Fainting / Dizziness**	❑ **Osteoporosis**
❑ **Rheumatism or Arthritis**	❑ **Asthma / Hay Fever**	❑ **Other**_____	

❑ **Organ / Valve / Joint / Replacement and/or Implant: Type:** _____

Doctor: _____ **Date:** _____

Initial:

_____ **I acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices."**

_____ **I Understand That Payment Is Due At Time Of Service.**

I will pay today by: ❑ CASH ❑ CHECK ❑ CREDIT CARD ❑ OTHER

Signature: _____ Date: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.