Beth C. Dunsmoor, DDS, PA

PATIENT REGISTRATION FORM

Patient Name	Patient Account #

PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____

Today's Date _____ Preferred Name _____ Gender: ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____ Ext. _____

Email _____ SSN _____ - _____ - _____

Driver's License Number _____ State _____ Birthdate _____

Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____

Spouse/Parent/Guardian's Name _____ Birthdate _____ SSN _____ - _____ - _____

Spouse's Employer _____ How did you hear about our practice? _____

DENTAL INSURANCE

Primary Insurance

Subscriber's Name _____ Relationship to Patient _____

Birthdate _____ Insurance Company _____ Group # _____

Secondary Insurance

Subscriber's Name _____ Relationship to Patient _____

Birthdate _____ Insurance Company _____ Group # _____

ACCOUNT INFORMATION

Person Financially Responsible for the Account

Name _____ Relationship _____ SSN _____

Address _____ City _____ State _____ Zip _____

Phone _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Phone _____

Cell Phone _____ Work Phone _____ Ext. _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge.

Patient/Guardian Signature _____ **Date** _____

Beth C. Dunsmoor, DDS, PA

DENTAL HISTORY FORM

Patient Name	Patient Account #

Welcome! *So that we may provide you with the best possible care, please complete both the Dental History form AND the Medical History Form. All information is completely confidential.*

What is the reason for your visit today? _____

Date of last dental visit: _____ Last cleaning: _____ Last full mouth x-rays: _____

What was done at your last dental visit? _____

Previous Dentist's Name: _____ Telephone #: _____

Address: _____ City: _____ State: _____ Zip: _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What other dental aids do you use (Interplak, toothpick, etc.)? _____

Do you have any dental problems now? ☐Yes ☐No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? ☐Yes ☐No
Sweets? ☐Yes ☐No
Biting or chewing? ☐Yes ☐No
Have you noticed any mouth odors or bad tastes? ☐Yes ☐No
Do you frequently get cold sores , blisters, or any other oral lesions? ☐Yes ☐No
Do your gums bleed or hurt? ☐Yes ☐No
Have your parents experienced gum disease or tooth loss? ☐Yes ☐No
Have you noticed any loose teeth or change in your bite? ☐Yes ☐No
Does food tend to become caught in between your teeth? ☐Yes ☐No
If yes, where? _____

Do you:

Clench or grind your teeth while asleep or awake? ☐Yes ☐No
Bite your lips or cheeks with regularity? ☐Yes ☐No
Hold foreign objects with your teeth (pencils, pipes, pins, nails, fingernails)? ☐Yes ☐No
Mouth breathe while awake or asleep? ☐Yes ☐No
Have tired jaws, especially in the morning? ☐Yes ☐No
Snore or have any other sleeping disorder? ☐Yes ☐No
Smoke/chew tobacco or use any other tobacco products? ☐Yes ☐No

Have you ever had:

Orthodontic treatment? ☐Yes ☐No
Oral surgery? ☐Yes ☐No
Periodontal treatment? ☐Yes ☐No
Your teeth ground or the bite adjusted? ☐Yes ☐No
A bite plate or mouth guard? ☐Yes ☐No
A serious injury to the mouth or head? ☐Yes ☐No
If so, please describe including the cause: _____
_____

Have you experienced:

Clicking or popping of the jaw? ☐Yes ☐No
Pain? (joint, ear, side of face) ☐Yes ☐No
Difficulty in opening or closing the mouth? ☐Yes ☐No
Difficulty in chewing on either side of the mouth? ☐Yes ☐No
Headaches, neckaches, or shoulder aches? ☐Yes ☐No
Sore muscles (neck, shoulders)? ☐Yes ☐No

Are you satisfied with your teeth's appearance? ☐Yes ☐No
Would you like to keep all of your teeth all of your life? ☐Yes ☐No
Do you feel nervous about having dental treatment? ☐Yes ☐No
If so, what is your biggest concern? _____
Have you ever had an upsetting dental experience? ☐Yes ☐No
If yes, please describe: _____
_____

Is there anything else about having dental treatment you would like us to know? ☐Yes ☐No

If yes, please describe: _____

_____

_____

Please be sure to also complete the Medical History Form.

Dentist Signature & Date	Medical Alert

Beth C. Dunsmoor, DDS, PA

MEDICAL HISTORY FORM

Patient Name	Patient Account #

1. Have you been under the care of a medical doctor during the past two years? ☐Yes ☐No
   If yes, for what?_____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ☐Yes ☐No
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? ☐Yes ☐No
   If yes, please list name and dosage _____
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine phentermine); Pondimen (fenfluramine); and Redux (dexfenfluramine)? ☐Yes ☐No
   If yes to the above, did you have a medical exam for heart issues? ☐Yes ☐No
5. Are you aware of having an allergic **or adverse** reaction to any medication or substance? ☐Yes ☐No
   If yes, please list _____
6. Have you been in the hospital during the past five years? ☐Yes ☐No
7. Indicate which of the following you have had, or have present.

Heart (Surgery, Disease, Attack) ☐Yes ☐No	Ulcers ☐Yes ☐No	Hepatitis ☐A ☐B ☐C ☐None
Chest Pain ☐Yes ☐No	Diabetes ☐Yes ☐No	Venereal Disease ☐Yes ☐No
Congenital Heart Disease ☐Yes ☐No	Thyroid Problems ☐Yes ☐No	A.I.D.S. ☐Yes ☐No
Heart Murmur ☐Yes ☐No	Glaucoma ☐Yes ☐No	H.I.V. Positive ☐Yes ☐No
High Blood Pressure ☐Yes ☐No	Contact Lenses ☐Yes ☐No	Cold Sores/Fever Blisters ☐Yes ☐No
Mitral Valve Prolapse ☐Yes ☐No	Emphysema ☐Yes ☐No	Blood Transfusion ☐Yes ☐No
Artificial Heart Valve ☐Yes ☐No	Chronic Cough ☐Yes ☐No	Hemophilia ☐Yes ☐No
Heart Pacemaker ☐Yes ☐No	Tuberculosis ☐Yes ☐No	Sickle Cell Disease ☐Yes ☐No
Rheumatic Fever ☐Yes ☐No	Asthsma ☐Yes ☐No	Bruise Easily ☐Yes ☐No
Arthritis/Rheumatism ☐Yes ☐No	Hay Fever ☐Yes ☐No	Liver Disease ☐Yes ☐No
Cortisone Medicine ☐Yes ☐No	Latex Sensitivity ☐Yes ☐No	Yellow Jaundice ☐Yes ☐No
Swollen Ankles ☐Yes ☐No	Allergies or Hives ☐Yes ☐No	Neurological Disorders ☐Yes ☐No
Stroke ☐Yes ☐No	Sinus Trouble ☐Yes ☐No	Epilepsy or Seizures ☐Yes ☐No
Diet (Special/Restricted) ☐Yes ☐No	Radiation Therapy ☐Yes ☐No	Fainting or Dizzy Spells ☐Yes ☐No
Artificial Joints (hip, knee, etc. ☐Yes ☐No	Chemotherapy ☐Yes ☐No	Nervous/Anxious ☐Yes ☐No
Kidney Trouble ☐Yes ☐No	Tumors ☐Yes ☐No	Psychiatric/Psychological Care ☐Yes ☐No

8. Do you use more than two pillows to sleep? ☐Yes ☐No
9. Have you lost or gained more than 10 pounds in the past year? ☐Yes ☐No
10. Do you have or have you had any disease, condition, or problem not listed? ☐Yes ☐No
    If yes, please list: _____
11. **Women:** Are you pregnant or think you might be pregnant? ☐Yes, _____ Months ☐No Nursing? ☐ Yes ☐ No
12. **Women:** Do you use birth control medications? ☐Yes ☐No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

BETH C. DUNSMOOR, DDS, PA
2771 NC HWY 55
CARY, NC 27519

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. In the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, radiography and the use of local anesthesia or nitrous oxide sedation, antibiotics or analgesics.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for ***all*** costs that my insurance does not cover.

5. I acknowledge that my treatment plan may change during treatment due to conditions found while working on the teeth that were not discovered during examination. I consent to changes in my treatment plan deemed necessary by Dr. Beth C. Dunsmoor and her staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I acknowledge that I am responsible for understanding and clarifying, to my satisfaction, all treatment.

7. This consent shall be considered in effect until rescinded or revoked.

_____ _____
Patient or Guardian Name Date

_____ _____
Witness Date