TRENTON FAMILY DENTAL CARE
DR. VASUDHA BASAVA, DDS, LLC
PATIENT REGISTRATION FORM
ALL INFORMATION WILL REMAIN CONFIDENTIAL

Today's Date: ____________________

Patient Name: ______________________________________ What name do you prefer to be called? __________
Last First M.I.

Home Address: ____
Street City State Zip

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

Date of Birth: ____________________ Social Security Number: ____________________ Sex: M F

Place of Employment: ______________________________ Occupation: ______________________________

Business Address: ____
Street City State Zip

Other family members seen here, if applicable: ____

Whom may we thank for referring you to this office? (Friend, Family, etc.) ________________________

Reason for today's visit: ____

Spouse (if applicable): Name ____________________ Date of Birth __________ Soc. Sec. Number __________

Address (if different from above): ____

Spouse's Place of Employment: ______________________________ Occupation: ____________________

In case of emergency, whom should we contact? ____
Name Relationship Phone

INSURANCE INFORMATION

Primary Insurance Company: ____
Name Address

Name of Insured: ______________________________ Group or Policy Number: ____________________

Secondary Insurance (if applicable): ____
Name Address

Name of Insured: ______________________________ Group or Policy Number: ____________________

Preferred Method of Payment (Cash, Check, Credit Card, CareCredit: ____________________

FINANCIAL AGREEMENT AND CONSENT

By signing below, I attest that the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Trenton Family Dental Care. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize Trenton Family Dental Care or insurance company to release any information required to process my claims. I understand and agree that, if a scheduled appointment is broken with less than 24 hours notice, I may be responsible for a fee of $70.00, and that multiple broken appointments may result in an inability to schedule further appointments at Trenton Family Dental Care.

Signature of Responsible Party: ______________________________ Date: ____________________

HEALTH QUESTIONNAIRE

Please circle yes or no to the following questions with a brief explanation when necessary. If you are unsure of an answer, please ask the doctor.

Primary Care Physician:

Physician's Name: ______________________ Telephone: ______________________

Yes No Are you in good health?

Yes No Are you now under the regular care of a physician for any problem?

Yes No Have you ever had any serious illness or operation?

If "yes" above, please explain: ______________________

Do you have, or have you ever had, any of the following:

Yes No Rheumatic Fever

Yes No Mitral Valve Prolapse

Yes No Heart Murmur

Yes No Heart Attack or Disease

Yes No Artificial Heart Valve

Yes No Chest Pain or Angina

Yes No Stroke

Yes No High Blood Pressure

Yes No Bleeding Disorder/Hemophilia

Yes No Artificial Joint

Yes No Cancer

Yes No Tuberculosis

Yes No Hepatitis or Liver Disease

Yes No Asthma, Pneumonia

Yes No Diabetes

Yes No Stomach Ulcers

Yes No Seizures

Yes No Kidney Disease

Yes No Frequent Headaches

Yes No Thyroid Condition

Yes No Sinusitis

Yes No Herpes Virus (cold sores)

Yes No AIDS or HIV+ Infection

Yes No Radiation or Chemotherapy

Yes No Psychiatric Therapy

Yes No Glaucoma or Eye Disease

Yes No Autoimmune Disease (other than HIV/AIDS)

Yes No Chronic Pain

Yes No Other Chronic Illness

Yes No Have you ever had abnormal bleeding? Specify: ______________________

Yes No Have you ever had treatment for a growth or tumor of the mouth or face area?
Specify: ______________________

Yes No Have you lost more than 10 pounds of weight in the last 3 months, without trying to lose weight?
Specify: ______________________

Yes No Please list any medications you are taking, for any reason: ______________________

Are you allergic to or sensitive to any of the following:

Yes No Local anesthetics such as "Novocaine"?

Yes No Penicillin, erythromycin, or other antibiotics?

Yes No Sulfa drugs?

Yes No Aspirin, codeine, other narcotics, or other pain medication?

Yes No Iodine?

Yes No Latex?

Yes No Nickel, gold, silver or other metal?

Yes No Other?

If you circled "Yes" above, please describe your reaction ______________________

Yes No Do you smoke cigarettes or chew tobacco? If so, how much? ______________________

Yes No Do you drink alcohol? If so, how much? ______________________

Yes No Do you use recreational drugs or had history of addiction? If so, with what? ______________________

Yes No Do you have any other disease, condition, or problem not listed above that you think we should know about?
Specify: ______________________

Yes No **(Women Only)** Are you pregnant or nursing?

Yes No **(Women Only)** Are you taking oral contraceptives?

DENTAL QUESTIONNAIRE

Date of last dental treatment: ______________ What was done at that visit? ______________________

Have you ever had trouble or problems with dental treatment? ______________________

What are your current concerns regarding your dental health? ______________________

I have reviewed the above questionnaire, and attest that all statements made are truthful and complete, to the best of my knowledge.

Signature of Patient/Guardian **Date** **Signature of Dentist** **Date**