Pickwick Family Dental Care

Patient Name:_____ Date: _____

PATIENT REGISTRATION

PATIENT REGISTRATION

ID		Chart ID	
Patient is:			
Policy Holder	Responsible Party		

Responsible Party

Is someone other than the patient the responsible party?

First Name	Last Name	Middle Initial	Address
Address 2	City	State	Zip
Home Phone	Work Phone	Ext	Cellular
Birth Date	Soc. Sec	Drivers Lic	Responsible Party is also a Policy Holder for Patient
Primary Insurance Policy Holder	Secondary Insurance Policy Holder		

Patient Information

Address	Address 2	City	State
Zip	Home Phone	Work Phone	Ext
Cellular	Sex	Marital Status	Birth Date
Age	Soc. Sec	Drivers Lic	E-mail
I would like to receive correspondences via e-mail.	Employment Status	Student Status	Medicaid ID
Employer ID	Carrier ID	Pref. Dentist	Pref. Pharmacy
Pref. Hyg			

INSURANCE

Primary Insurance Information

Does the patient have dental insurance coverage?

Name of Insured	Relationship to Insured	Insured Soc. Sec	Insured Birth Date
Employer	Employer Address	Employer Address 2	City
State	Zip	Ins. Company	Ins. Company Address
Ins. Company Address 2	City	State	Zip
Rem. Benefits		Rem. Deduct	

Secondary Insurance Information

Does the patient have secondary dental insurance coverage?

Name of Insured	Relationship to Insured	Insured Soc. Sec	Insured Birth Date
Employer	Employer Address	Employer Address 2	City
State	Zip	Ins. Company	Ins. Company Address
Ins. Company Address 2	City	State	Zip
Rem. Benefits		Rem. Deduct	

MEDICAL HISTORY

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Birth Date	Are you under a physician's care now?	Have you ever been hospitalized or had a major operation?	Have you ever had a serious head or neck injury?
Are you taking any medications, pills or drugs?	Do you take, or have you taken, Phen-Fen or Redux?	Have you ever taken Fosamax,Boniva, Actonel or any other medications containing bisphosphonates?	Are you on a special diet?
Do you use tobacco?	Do you use controlled substances?		
Women: Are you...			
Pregnant / trying to get pregnant?	Nursing?	Taking oral contraceptives?	

Are you allergic to any of the following?

Aspirin	Metal	Metal	Penicillin
Latex	Codeine	Sulfa Drugs	Acrylic
Local Anesthetics	Others?	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Alzheimer's Disease	Anaphylaxis	Anaemia
Angina	Arthritis/Gout	Artificial Heart Valve	Artificial Joint
Asthma	Blood Disease	Blood Transfusion	Breathing Problems
Bruise Easily	Cancer	Chemotherapy	Chest Pains
Cold Sores/Fever Blisters	Congenital Heart Disorder	Convulsions	Cortisone Medicine
Diabetes	Drug Addiction	Easily Winded	Emphysema
Epilepsy or Seizures	Excessive Bleeding	Excessive Thirst	Fainting Spells/Dizziness
Frequent Cough	Frequent Diarrhea	Frequent Headaches	Genital Herpes
Glaucoma	Hay Fever	Heart Attack/ Failure	Heart Murmur
Heart Pacemaker	Heart Trouble/Disease	Haemophilia	Hepatitis A
Hepatitis B or C	Herpes	High Blood Pressure	High Cholesterol
Hives or Rash	Hypoglycemia	Irregular Heartbeat	Kidney Problems
Leukaemia	Liver Disease	Low Blood Pressure	Lung Disease
Mitral Valve Prolapse	Osteoporosis	Pain in Jaw Joints	Parathyroid Disease
Psychiatric Care	Radiation Treatments	Recent Weight Loss	Renal Dialysis
Rheumatic Fever	Rheumatism	Scarlet Fever	Shingles
Sickle Cell Disease	Sinus Trouble	Spina Bifida	Stomach/Intestinal Disease
Stroke	Swelling of Limbs	Thyroid Disease	Tonsillitis
Tuberculosis	Tumours or Growths	Ulcers	Venereal Disease
Yellow Jaundice	Have you ever had any serious illness not listed above?		
Comments:			

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:	Date

PATIENT SCREENING QUESTIONNAIRE

Patient Screening Questionnaire

Please answer the following questions based on your pre-appointment state.

Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	**Are you/they having shortness of breath or other difficulties breathing?**	**Do you/they have a cough?**	**Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?**
Are you/they in contact with any confirmed COVID-19 positive patients?			
Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.			
Is your/their age over 70?	**Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?**	**Have you/they traveled in the past 14 days?**	

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

State and Territorial Health Department Websites

Signature

The information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes

Signature of Patient, Parent, or Guardian	**Date**