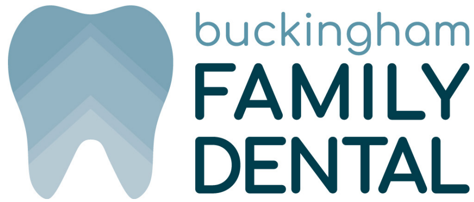


New Patient Registration

First Name________________________ Last Name_________________________ Phone________________________
Date of Birth: _________________ Social _______________________ Email Address ____________________________
Address ____ City____________________ State _________ Zip__________

Employer ______________________________ Occupation ______________________ Work Phone _______________
Employer Address _______________________________ City ____________________ State ________ Zip __________

Responsible Party if Other than Patient:

First Name:________________________ Last Name_________________________ Phone_______________________
Date of Birth: _________________ Social _______________________ Email Address ___________________________
Address ____ City___________________ State _________ Zip__________

Employer ______________________________ Occupation ______________________ Work Phone _______________
Employer Address _______________________________ City ____________________ State ________ Zip __________

Emergency Contact

First Name________________________ Last Name__________________________ Phone_______________________
Address ____ City____________________ State _________ Zip__________

Insurance Information

Insurance Name ____________________________ Policy Number _______________________ Group # ____________
Policyholder Name ________________________________ D.O.B.___________________ Social # __________________
Insurance Phone Number ____________________________

How did you hear about us?

A friend/patient ________________________ A Doctor ____________________ Insurance _________________________
Staff ________________________________ Drove By __________ Website_______ Google______ Facebook ______

Primary Physician

Name _____________________ Address __________________________ City______________State ____Zip__________
Phone _________________________ Fax ___________________ Email ____

Health History

Primary Concerns: _____________________ When was the last time you visited the dentist: _______________________
Are you sensitive to HOT foods or liquids?:_____________ Are you sensitive to COLD foods or liquids?:_____________
How often are you brushing your teeth?: __________________ Do your gums bleed?: ____________________________
Do you grind your teeth?: ______________________ Do you have any pain in your jaw?: _________________________
Do you want to change the arrangement of your teeth?: ____

For Women:

Are you taking birth control pills? _______ Are you pregnant?________ Week #: _______ Are you nursing? _________

Do you or have you experienced any of the following? (Please circle Y/N)

Y N Abnormal Bleeding	Y N Colitis	Y N Liver Disease	Y N Alcohol Use
Y N Congenital Heart Defect	Y N Heart Surgery	Y N Lupus	Y N Anemia
Y N Hemophilia	Y N Pacemaker	Y N Artificial Bones/Joints	Y N Emphysema
Y N Hepatitis	Y N Radiation Treatment	Y N Artificial Valves	Y N Fever Blisters
Y N Herpes	Y N Seizures	Y N Asthma	Y N Glaucoma
Y N High Blood Pressure	Y N Tobacco Use	Y N Cancer	Y N Headaches
Y N HIV+/AIDS	Y N Tuberculosis (TB)	Y N Chemotherapy	Y N Heart Attack
Y N Kidney Problems	Y N Venereal Disease	Y N Diabetes	Y N Heart Murmur

Are you allergic to any of the following? (Please circle Y/N)

Y N Aspirin	Y N Erythromycin	Y N Sedatives	Y N Barbiturates
Y N Jewelry/Metals	Y N Sulfa Drugs	Y N Codeine	Y N Latex
Y N Tetracycline	Y N Dental Anesthetics	Y N Penicillin	Y N Other

Are you currently taking any medications? Please list any medications you may be taking below:

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

I understand that I am responsible for payment of services rendered by Buckingham Family Dental, and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the Buckingham Family Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Buckingham Family Dental of any changes in my medical status. I truthfully revealed all aspects of my/my child's health history and I realize that failure to have done so may have negative consequences for my/my child's health and the success of my/my child's treatment.

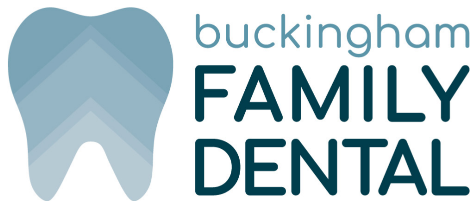
I agree to cooperate fully with the recommendations of the Dentist and Dental Hygienist and I realize that failure to do so may result in less than optimum results and compromise the life span of my/my child's treatment. I also agree to follow the recommendations for home care and the schedule for future tooth cleaning and check-ups. I realize that failure to do my part in the maintenance of my/my child's oral health will compromise the success of any dental treatment received.

I hereby authorize Buckingham Family Dental and staff to take radiographs, study models, intraoral photographs, or any other diagnostic tools, all deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform any and all forms of treatment including cleaning, fluoride and sealants (back teeth have grooves and pits in which decay usually starts. An assistant will "seal" the grooves with a plastic coating to help prevent the decay from starting. No anesthetic is needed. Good oral hygiene and avoidance of sticky and hard food/candles are important to maintain sealants). **And further authorize and consent that the dentist choose and employ such assistance as she deemed fit.** I understand that antibiotics, local anesthesia ("shots") and all other medications given to the patient before, during and after treatment, can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Administration of local anesthesia ("shots") may cause nerve damage (paresthesia) that can last for days, months or indefinitely. Women of childbearing age need to know antibiotics may make birth control medications ineffective and need to rely on other methods of birth control to prevent pregnancy.

I understand and acknowledge that I may choose not to be treated by the dentist. The dentist has explained to me the reasonably foreseeable risks associated with not treating my condition. Alternative treatment plans with their foreseeable associated risks and benefits have been adequately presented to me.

Signature:______________________________ Date:______________________________

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



I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third- party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient Name: ____

Signature: ____ **Date**____________________

Relationship to Patient: Self or Guardian (please circle one)