Emergency Registration and Health History

SOUTHPOINTE DENTAL
Susan Althoff DDS

Patient Name: ________________________________Today's Date _______________

Address: ____ DOB: _____________________

City: _______________________________ State: __________________________Zip:_____________________

Home Phone:______________________Cell Phone:______________________Email:_______________________

Text Confirmations for appointments? Yes / No (circle one) T-Mobile AT&T Verizon Sprint

Emergency Contact Person: _________________________Best Contact Phone: ___________________________

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Has there been a change in your health within the last year? YES NO

If YES, explain ____

Are you being treated by a physician now? YES NO

If YES, explain ____

DO YOU SMOKE OR USE TOBACCO PRODUCTS? YES NO If YES, please list:______________________

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Select All That Apply)

❑ Aspirin Allergy	❑ Antibiotics	❑ Codeine Allergy	❑ Latex Allergy
❑ Penicillin Allergy	❑ Local Anesthetic	❑ Novocain	❑ Food:_____________________________

Other Allergies: ____

MEDICAL CONDITIONS - (Select All That Apply)

❑ Arthritis	❑ Acid Reflux	❑ Artificial Joints	❑ Asthma
❑ Artificial Heart Valve	❑ Blood Disorder	❑ Cancer / Tumor	❑ Chemotherapy or Radiation
❑ Chemical Dependency	❑ Cosmetic Surgery	❑ Diabetes	❑ Digestive Problems
❑ Damaged Heart Valve	❑ Eating Disorder	❑ Emphysema	❑ Headaches/Migraines
❑ High Blood Pressure	❑ Heart Attack / Disease	❑ Hepatitis / Liver Disorder	❑ HIV+ / AIDS
❑ Herpes	❑ Hay Fever	❑ Kidney Disease/Trouble	❑ Lung Disease
❑ Low Blood Pressure	❑ Osteoporosis	❑ Persistent Cough	❑ Pregnant or Nursing
❑ Psychiatric Care	❑ Pacemaker	❑ Respiratory Problems	❑ Skin Disease
❑ Stroke	❑ Sinus Trouble	❑ Sleep Apnea/CPAP	❑ STD
❑ Seizures / Epilepsy	❑ Tuberculosis (TB)	❑ Surgery: ____	

❑ Other: ____

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST *THREE* MONTHS? (circle)

Antibiotics Aspirin Coumadin Blood Thinners Birth Control:____________

Recreational Drugs Bisphosphonates: Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, Skelid

MEDICATIONS AND PRESCRIPTIONS: Please list any supplements, prescriptions or recreational drugs:

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Is there any issue or condition that you would like to discuss with the dentist in private? YES NO

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Patient Name: ____________________________________ DOB: _____________________

DENTAL INFORMATION

Do You Know When Your Last Dental Visit May Have Been? ____

Do You Recall The Name of that Dentist?__________________________________ Location:_______________________

Describe your Discomfort: ❑ Throbbing ❑ Swelling ❑ Aching **Sensitive To*:*** ❑ Hot ❑ Cold ❑ Pressure

How Long? _________________________________ Does It Keep You Up At Night? ______________________________

Chief Complaint:

❑ Toothache ❑ Broken Tooth ❑ Broken Filling ❑ Crown Off

❑ Gum Problem ❑ Broken Denture/Partial ❑ Loose Tooth ❑ Loose Crown or Bridge

❑ Jaw Pain ❑ Sensitive Teeth ❑ Sore or Lump in Mouth

Location: ❑ Upper Left ❑ Upper Right ❑ Lower Left ❑ Lower Right

Do you have any of the following? ❑ Blood Thinners ❑ Pacemaker ❑ Heart Disease

Have you ever taken an antibiotic prior to dental treatment? Yes No

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FINANCIAL INFORMATION

Who is responsible for this account? ______________________________ Employed By:___________________________

Responsible Party Date Of Birth: ________________________ SSN: _____________________________________

Method of payment: ❑ Insurance ❑ Credit Card ❑ Cash/Check ❑ Care Credit

DENTAL INSURANCE

Policy Holder Name ____ DOB _______________________

Relation to Patient____________________________Employer____

Insurance Company ______________________________ Address ____

Insurance ID Number / SSN___________________________________ Group Number ___________________________

RELEASE:

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr Althoff of any change in my health and/or medication. I will not hold Dr Althoff or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

I authorize Dr Althoff and his team to perform diagnostic procedures and any necessary treatment

I understand that this examination is going to address my immediate problem and should not be considered a complete examination with resulting treatment.

If the Dr Althoff determines that there may be a medically-compromised situation, I authorize Southpointe Dental to contact my physician prior to dental treatment.

I authorize and request my insurance company to pay directly to Southpointe Dental any insurance benefits otherwise payable to me. I authorize Southpointe Dental to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize the use of this signature on all insurance submissions.

In addition, I authorize Southpointe Dental to use *anonymous* photos of my teeth for publications, web pages and other educational materials produced and representing Southpointe Dental without compensation to me.

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Patient, Parent or Guardian Signature Date

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Relationship to Patient if Applicable