Southpointe Dental
James Lichtsinn, DDS
3210 18th Street South
Fargo, ND 58104
Phone (701) 280-1941

Emergency Registration and Health History

Patient Name: _____ **Date** _____

Address: _____ **DOB:**_____

Home Phone: _____ Cell Phone: _____

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

Person to contact in emergency: _____Best Contact Phone: _____

CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

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

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? (Please 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:

_____

_____

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

DENTAL INFORMATION

How long has it been since your last dental visit? _____ What was done at that time? _____

Reason for today's visit? _____

_____

How long have you been experiencing discomfort with this? _____

FINANCIAL INFORMATION

Patient/Parent Employed By:_____ Who is responsible for this account? _____

Responsible Party Date Of Birth: _____ SSN: _____

Method of payment: Insurance____ Credit Card _____ Cash _____ Care Credit _____

DENTAL INSURANCE

Employee Name: _____ Employee Date of Birth: _____

Employer: _____ Relationship to Patient: _____

Name of Insurance: _____

Address: _____

Telephone: _____ ID # or SS#:_____Group #_____

RELEASE:

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potential medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician. I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

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

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental or medical care payor.

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.

Patient/Guardian Signature_____**Date:**_____