SCOTT HUDIMAC DDS
Improving Smiles, Improving Lives

PATIENT REGISTRATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

How do you wish to be addressed? _____ Date of Birth: _____ Soc Sec #: _____ Gender: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ Telephone (Work): _____ Telephone (Cell): _____ Texting Ok? Yes ☐ No ☐

Employer/School: _____ Employer/School Phone: _____

Email Address: _____ How did you hear about our practice? _____

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name: _____

DENTAL INSURANCE INFORMATION (*Please present your insurance card to be photocopied for our records)*

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Insurance Company:	Insurance Company:
Subscriber Name:	Subscriber Name:
Subscriber ID/Social Security #:	Subscriber ID/Social Security #:
Date of Birth:	Date of Birth:
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name:	Employer Name:
Employer Phone #:	Employer Phone #:
Group Number:	Group Number:

RESPONSIBLE PARTY (*if Minor*)

Name: _____ Relationship to Patient: _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ Telephone (Work): _____ Telephone (Cell): _____ Texting Ok? Yes ☐ No ☐

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Phone (☐ Home ☐ Cell): _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by Dr. Hudimac, and to the release of information concerning my (or my child's) health care, advice and treatment to another dentist for evaluation & consult, and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to Dr. Hudimac and understand that my insurance benefits may pay less than the actual bill and that I am responsible for any services not paid or covered by my insurance benefits and any account balance. ☐ I CONSENT ☐ I DO NOT CONSENT

ELECTRONIC COMMUNICATIONS:

I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these communications. Message/Data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails or by replying STOP. ☐ I CONSENT ☐ I DO NOT CONSENT

DENTAL & MEDICAL HEALTH HISTORY

PATIENT NAME _____ **PLEASE COMPLETE ALL INFORMATION – THANK YOU!**

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former Dentist _____ Date of last dental x-rays_____

PLEASE CHECK IF YOU HAVE/HAD	YES	NO		YES	NO
Abscesses	☐	☐	Gums swollen/tender/bleeding	☐	☐
Bad Breath	☐	☐	Head/Neck/Jaw pain or aches	☐	☐
Blisters on lips or mouth	☐	☐	Lip or cheek biting	☐	☐
Burning sensation on tongue	☐	☐	Loose teeth or broken fillings	☐	☐
Chew on one side of mouth	☐	☐	Mouth Breathing	☐	☐
Cigarette/pipe/cigar/vape	☐	☐	Orthodontic Treatment	☐	☐
Smokeless Tobacco	☐	☐	Nitrous Oxide	☐	☐
Dry Mouth	☐	☐	Periodontal Treatment	☐	☐
Food collection between teeth	☐	☐	Sensitivity to pressure/irritants	☐	☐
Clench or Grind Teeth	☐	☐	(hot/cold/sweets)		
Growths or sore spots in mouth	☐	☐			

How often do you floss? _____

How often do you brush? _____

Have you ever had an allergic reaction to local or general anesthetics? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

MEDICAL HISTORY

Physician's Name _____ Phone Number _____ Date of last visit _____

Have you had any serious illnesses or operations? Yes ☐ No ☐ If Yes please describe _____

_____

PLEASE CHECK IF YOU HAVE/HAD	YES	NO		YES	NO		YES	NO
Acid Reflux/GERD	☐	☐	Glaucoma	☐	☐	Shortness of Breath	☐	☐
Allergies/Hay Fever/Sinusitis	☐	☐	Headaches	☐	☐	Sickle Cell Anemia	☐	☐
Anemia	☐	☐	Heart Attack	☐	☐	Sinus Trouble	☐	☐
Arthritis	☐	☐	Heart Disease	☐	☐	Skin Rash	☐	☐
Artificial Heart Valves	☐	☐	Heart Murmur	☐	☐	Sleep Apnea	☐	☐
Artificial Joints	☐	☐	Hepatitis Type _____	☐	☐	Slow Healing Wounds	☐	☐
Asthma	☐	☐	Herpes	☐	☐	Special Diet	☐	☐
Abnormal Bleeding w/Surgery	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Blood Disease, Clotting Disorders	☐	☐	Immune Deficiency	☐	☐	Swelling of feet or ankles	☐	☐
Cancer / Chemotherapy	☐	☐	Jaundice	☐	☐	Thyroid Problems	☐	☐
Chemical Dependency	☐	☐	Kidney Disease	☐	☐	Tonsillitis	☐	☐
Circulatory Problems	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Cortisone Treatments	☐	☐	Low Blood Pressure	☐	☐	Tumor or growth on head/neck	☐	☐
Cough, persistent or bloody	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers	☐	☐
Diabetes Type _____ Last A1C _____	☐	☐	Osteoporosis	☐	☐	STD	☐	☐
Emphysema/COPD/Respiratory Issues	☐	☐	Pacemaker	☐	☐	Unexplained Weight Loss	☐	☐
Epilepsy	☐	☐	Radiation Treatments	☐	☐	Autoimmune Disorders_____		
Fainting Spells	☐	☐	Rheumatic Fever	☐	☐	_____		

(For Women)

Taking Birth Control? ☐ Yes ☐ No Are you Pregnant? ☐ Yes ☐ No Due Date _____ Nursing ☐ Yes ☐ No

MEDICATIONS

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you taking any Blood thinners? _____

PHARMACY _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping Pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine

☐ Latex ☐ **NONE**

Other Allergies _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge

Patient/Guardian Signature _____ Date _____