WEDGWOOD DENTAL CENTER

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Patient Registration

PATIENT NAME: (Last, First, Middle Initial)			DATE OF BIRTH:
ADDRESS:			SOCIAL SECURITY NO:
CITY, STATE, ZIP:			MARITAL STATUS: ☐ Single ☐ Married
HOME PHONE:	CELL PHONE:	WORK PHONE:	BEST CONTACT METHOD: ☐ Home ☐ Cell ☐ Work ☐ Email
PREFER: ☐ Morning Appointment ☐ Afternoon Appointment			RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child
E-MAIL ADDRESS:			SEX: ☐ Male ☐ Female

Other members of your family seen by this office:

NAME:	DATE OF BIRTH:	SOCIAL SECURITY NO:
NAME:	DATE OF BIRTH:	SOCIAL SECURITY NO:

Who should be notified locally in case of emergency?

NAME:	PHONE:
ADDRESS:	

Whom may we thank for referring you? ☐ Insurance List ☐ Website ☐ Sign ☐ Dental Professional ☐ Other:

NAME:	PHONE:

Insurance Information:

PRIMARY COVERAGE	SECONDARY COVERAGE
SUBSCRIBER'S NAME:	SUBSCRIBER'S NAME:
DATE OF BIRTH:	DATE OF BIRTH:
INSURANCE COMPANY:	INSURANCE COMPANY:
SOCIAL SECURITY or ID NO.:	SOCIAL SECURITY or ID NO:
GROUP NUMBER:	GROUP NUMBER:
LOCAL NUMBER OR POLICY NO.:	LOCAL NUMBER OR POLICY NO.:
EMPLOYER:	EMPLOYER:
OCCUPATION:	OCCUPATION:

UPDATED ON: SIGNATURE: DATE:

INFORMED CONSENT

1. Examinations and X-Rays.
I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan. (Initials _____)

2. Drugs, Medications, and Sedation.
I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours, or until fully recovered from the effects of the anesthetic, medications and drugs that may have been given me in the office for my care. I understand that failure to take medication as prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain, and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. (Initials _____)

3. Changes in Treatment Plan. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials _____)

4. Temporomandibular Joint Dysfunction (TMD). I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment, wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility. (Initials _____)

NAME (PRINTED):	SIGNATURE:	DATE:
DOCTOR:	WITNESS:	