Fleming Family Dentistry & Aesthetics

4728 Limerick Drive, Suite B
Carmel, Indiana 46033
(317) 848-1884

Patient Registration Form

General Information

Date ______________ Social Security Number _______-___-______

Patient Name ____
Last Name First Name Middle Initial (optional)

Address ____
Number Street Apt. # (If applicable)

City ____________________________ State ______________ Zip Code ______________

Home Phone # (____)______________ Work Phone # (____)______________ Cell Phone # (____)________________

E-mail ____

Gender M _____ F _____ Date of Birth ___/___/_____ Age ________

Marital Status Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Occupation ____

Patient Employer/School ____

Spouse's Name (if applicable) ____

Name of Responsible Party ____________________________________ Relationship to patient ________________

Responsible Party Date of Birth ___/___/_____ Responsible Party SSN _______-___-_______

Whom may we thank for referring you? ____

Dental Insurance

Primary Insurance Company ____ Phone # (____)______________

Primary Insurance Holder's Name ____

Group Number __________________________ Primary Insurance Holder's Employer ____________________

Primary Insurance Holder's Birthday ___/___/_____ Primary Insurance Holder's SSN _______-___-_______

Relationship to Patient ____

Is patient covered by additional insurance? Y _____ N _____

Secondary Insurance Company ____ Phone # (____)______________

Secondary Insurance Group Number ____

Secondary Insurance Holder's Birthday ___/___/_____ Primary Insurance Holder's SSN _______-___-_______

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with ________________________________ (Name of Insurance Company) and assign directly to Dr. Fleming all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ____
Signature of Patient, Parent, Guardian or Representative Please Print Name

____ ____
Date Relationship to the Patient and

Emergency Information

In case of an emergency, contact:

1. Name ________________________________ Relationship ___________ Phone # (____)______________
2. Name ________________________________ Relationship ___________ Phone # (____)______________
3. Name ________________________________ Relationship ___________ Phone # (____)______________

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Dental History

Reason for today's visit ____

Former Dentist ______________________ City/State ______________________

Date of last dental visit __________________ Date of last dental X-rays ____________________

Place an x in the box to indicate if you have the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on mouth/cold sores
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth
- ☐ Other: __________________

How often do you floss? ____________________ How often do you brush? ____________________

Medical History

Physician's Name __________________________ Physician's Phone # (____)______________ Date of last visit ______

Have you ever been hospitalized or had a major operation? Y _____ N _____ If yes, please explain. _________________

Have you ever had a serious head or neck injury? Y _____ N _____ If yes, please explain. ________________________

Have you ever taken any of the drugs collectively referred to as "fen-phen"? This include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Y _____ N _____

Place an x in the box to indicate if you have the following:

- ☐ AIDS/HIV
- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Bones/Joints
- ☐ Artificial Heart/Valves
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Circulatory Problems
- ☐ Congenital Heart Disorders
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type ____
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on neck/head
- ☐ Ulcer
- ☐ Weight Loss, unexplained
- ☐ Other:

____
____
____

FEMALES:

Are you pregnant? ____________________ Due Date ____________________

Are you nursing? ____________________ Taking birth control pills? ____________________

Medications

List any medications you are currently taking and and the correlating diagnosis:

____
____
____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other:

____

Pharmacy Name: ____

Phone # (____) _______-_______

To the best of my know ledge, the questions on this form have been accurately answered. I understand that providing incorrect information can dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GURARDIAN______________________________________ DATE___________