PATIENT REGISTRATION
(PLEASE PRINT CLEARLY)

Date _____

Patient's Full Name _____ Birth Date _____

Single ☐
Widowed ☐
Married ☐
Divorced ☐
Separated ☐

If a Child, Parent's Name _____

Name of Spouse _____ Birth Date _____

Street Address _____ Phone _____

City _____ State _____ Zip _____

Patient's Social Security Number _____

Spouse's Social Security Number _____

Patient Employed by _____ Phone _____

Business Address _____

Present Position _____ How Long Held? _____

Spouse Employed by _____ Phone _____

Business Address _____

Present Position _____ How Long Held? _____

Person Responsible for this Account _____

Purpose of the Appointment _____

In Case of Emergency, Who Should be Notified _____ Phone _____

If You Have Insurance, Name of Insured _____

Name of Insurance Company _____ Policy Number _____

Whom May We Thank for Referring You _____

Your Signature _____

Comments: _____

_____

_____

PRACTICE POLICY: IT IS THE POLICY OF THIS PRACTICE THAT FEES BE PAID AT THE TIME SERVICES ARE RENDERED. We feel regular visits and preventive treatment are your best protection against long and costly procedures. However, when the costs of necessary treatment exceeds your budget, we have available options for extended payments which we can arrange in advance of treatment.

X _____
Signature of Responsible Party Date

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Birth date _____ Age _____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____		
3. Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain _____		
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
5. (Women) Are you pregnant? If so, give due date _____	☐	☐
6. Do you use tobacco in any form? If yes, how much _____	☐	☐
7. Do you use alcoholic beverages (more than 2 drinks per day)?	☐	☐

8. Do you have or have you ever had any of the following?

GENERAL	YES	NO
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐
EYES		
Visual change	☐	☐
Glaucoma	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other	☐	☐

HEART/BLOOD VESSELS	YES	NO
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other	☐	☐
BONE/MUSCLES		
Arthritis/rheumatism	☐	☐
Artificial joints/limbs	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
URINARY		
Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
OTHER		
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
HIV+	☐	☐
AIDS	☐	☐

Form 4046

Please complete reverse side

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO
Local anesthetics (e.g. novocaine)	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐
Penicillin/other antibiotics	☐	☐
Aspirin or codeine	☐	☐
Sulfa drugs	☐	☐
Other allergies _____		

10. Are you taking any of the following?

	YES	NO
Antibiotics/sulfa drugs	☐	☐
Blood thinners	☐	☐
Blood pressure medication	☐	☐
Thyroid medicine	☐	☐
Cortisone/steroids	☐	☐
Antihistamines/allergy drugs/ cold remedies	☐	☐
Tranquilizers	☐	☐
Insulin/other diabetes drugs	☐	☐
Recreational drugs	☐	☐
Digitalis/other heart medications	☐	☐
Nitroglycerin	☐	☐
Aspirin	☐	☐
Other medication _____		

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1. _____
2. _____
3. _____
4. _____

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

12. Physician's Name _____ Phone _____

13. Have you ever had any serious trouble associated with previous dental treatment? _____

14. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

15 Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

If so, when? _____

17. Do you have or have you ever had any of the following?

MOUTH

	YES	NO
Bleeding, sore gums	☐	☐
Unpleasant taste/bad breath	☐	☐
Burning tongue/lips	☐	☐
Frequent blisters, lips/mouth	☐	☐
Swelling/lumps in mouth	☐	☐
Ortho treatments (braces)	☐	☐
Biting cheeks/lips	☐	☐
Clicking/popping jaw	☐	☐
Difficulty opening or closing jaw	☐	☐

TEETH

	YES	NO
Loose teeth	☐	☐
Sensitive to hot	☐	☐
Sensitive to cold	☐	☐
Sensitive to sweets	☐	☐
Sensitive to biting	☐	☐
Food impaction	☐	☐
Clenching/grinding	☐	☐
Shifting of teeth	☐	☐
Change in bite	☐	☐

ORAL HYGIENE

Do you use the following?	YES	NO
Brush	☐	☐
Dental floss	☐	☐
Fluoride rinse	☐	☐

Other _____

How often do you brush _____

Brush is: Soft ☐ Medium ☐ Hard ☐

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient
Parent, or Guardian _____ Date _____

Alternative Contacts Form

Dr. Chris Mott and staff take your confidentiality seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with an individual you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care.

As part of our **Patient Privacy Policy**, we will not leave any health information with any other person unless you specifically authorize below:

1. Person:_____ Relationship:_____
   Phone Number:_____
   __ Appointments __ Account Information __ Treatment

2. Person:_____ Relationship:_____
   Phone Number:_____
   __ Appointments __ Account Information __ Treatment

3. Person:_____ Relationship:_____
   Phone Number:_____
   __ Appointments __ Account Information __ Treatment

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form.

Patient Signature _____ **Date**_____

Chris A. Mott, D.D.S.,A.P.D.C.
631 Milam, Suite 101
Shreveport, La 71101-3500
(318) 424-7113

RESPECT FOR APPOINTMENTS

I agree that broken appointments are a disappointment for everyone. They interfere with dental Treatment and cause unnecessary scheduling problems. I also understand that this office will make very effort to make appointments that are most convenient for me and fit my personal schedule. I agree to come in on time and I understand that if I am late for any appointments we may not be able to complete all the work that we had planned and that can mean additional appointments. I agree not to change my appointment time once it is made. We understand that there can be extenuating circumstances no matter how faithful you try to be. Your cooperation in this matter is greatly appreciated. We value you as a respected member of our dental practice.

_____ _____

Signature of patient or guardian if minor Date

CHRIS A. MOTT D.D.S. A.P.D.C.

631 MILAM SUITE 101

SHREVEPORT. LA 71101-3500

AS A PATIENT OF DR. CHRIS A. MOTT I HAVE READ AND RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THIS OFFICE. I UNDERSTAND AND AGREE TO THESE PROVISIONS.

_____ _____

PRINT NAME DATE

_____ _____

SIGNATURE DATE

CHRIS A. MOTT, D.D.S., A.P.D.C.
631 MILAM, SUITE 101
SHREVEPORT, LA 71101-3500
(318) 424-7113

INSURANCE UNDERSTANDING FORM AND AUTHORIZATION OF DIRECT PAYMENT

I Here by authorize direct payment to Dr. Chris A. Mott, A.P.D.C.,631 Milam Suite 101, Shreveport, La. 71101-3500.

I agree and understand that I am fully responsible for total payment of procedures performed in this office, including any amounts which are not covered by any insurance or prepaymentprogram that the patient may have.

Co-payments are due at the time of the visit unless payment arrangements have been made in advance.

_____ _____

Signature of patient or guardian if minor **Date**