Print from Website

Registration Form & Patient Consent to Treat

General Information

Patient's Name_____Name to be called_____
Address_____City, State_____Zip Code_____
Sex M F / Date of Birth_____Age____ Marital Status S M D W /Social Security #_____
Home Telephone_____Work Telephone_____Cell Phone_____Other_____
Parent's or Guardian's
Name_____Address_____
Home Telephone_____Work Telephone_____Cell Phone_____Other_____
All Insurance Company(s)_____ School:_____Language spoken in home_____

How did you hear about us?

Family/Friend (Name)_____Dentist_____ Health Dept_____
☐TennCare ☐School ☐Phone Book ☐ TV ☐Radio ☐Health Fair ☐ Other _____

Medical Information

Physician's Name_____Phone Number_____
List medications the patient is **taking**_____
List medications the patient is **allergic to**_____

Been to another dentist in the last six months? Yes__ No__What is the purpose of this visit?_____
Does patient drink: ☐ well water ☐ bottled water ☐ city water
Does the patient have or ever had:

Yes/No		**Yes/No**		**Yes/No**	
ADHD	__ __	Seasonal Allergies	__ __	Anemia	__ __
Asthma	__ __	Autism	__ __	Bleeding Disorder	__ __
Blood Transfusion	__ __	Brain Damage	__ __	Bipolar	__ __
Cancer	__ __	Cerebral Palsy	__ __	Diabetes	__ __
Down Syndrome	__ __	Epilepsy	__ __	Hearing Disorder	__ __
Heart Condition	__ __	Hepatitis	__ __	HIV Positive	__ __
High Blood Pressure	__ __	Kidney Disorder	__ __	Latex Allergy	__ __
Liver Disorder	__ __	Lung Problems	__ __	Radiation Therapy	__ __
Reaction to Anesthesia	__ __	Sickle Cell Disease	__ __	Sickle Cell Trait	__ __
Speech Disorder	__ __	Recent Eye Surgery	__ __	Tuberculosis	__ __
Reaction to Fluoride	__ __	Vision Disorder	__ __		
Are you pregnant	__ __	Are you nursing	__ __	Birth Control	__ __
Due Date _____					

Please list other medical conditions OR allergies the patient has_____

CONSENT TO TREAT

Western Heights Dental has my permission to treat my child or my self's dental needs by using but not limited to amalgams (silver fillings), composites (tooth colored fillings), porcelain or stainless steel crowns, Nitrous Oxide (laughing gas), and fluoride. Western Heights Dental has my permission to perform if needed but not limited to dental x-rays, professional cleanings, extractions (removal of teeth), root canals, frenectomys and limited oral surgery or any other treatment associated with dentistry.

I agree to cooperate completely with the recommendations of the doctor while I or this patient is under her/his care, realizing that any lack of same could result in less than optimum results. I am aware cell phone use **is not allowed beyond reception area** and violators will be asked to return to reception area and/or leave the building. Includes: calls, texting, camera and video. Cell phones violate HIPPA laws.

I certify that I have had an opportunity to read and fully understand the terms and words within the above, including the opposing side of this document, and consent to the cooperation and explanation referred to or made, and have given true and accurate information to the best of my knowledge. I have been encouraged to ask questions, and have had them answered to my satisfaction.

Signature_____Relationship to Patient_____Date_____

CONTINUED ON THE REVERSE SIDE