ARCH
DENTAL

Registration Form

Please fill out accurately and completely. The confidential information requested is important for your treatment and insurance claim.

Patient Information

Patient Name: _____ Gender: _____ Date of Birth: _____

Home Address: _____

Mailing Address: _____

E-mail Address: _____

Phone: Home: _____Cell:_____Work: _____

Employed by: _____Occupation: _____

Social Security Number: _____ (need only if used for insurance id)

Dental Insurance: _____ID #: _____

Subscriber Name: _____Date of Birth: _____

Secondary Dental Ins: _____Subscriber Name: _____

How were you referred to our office? _____

Emergency Contact Information

Name: _____Date of Birth: _____

Employed by: _____Occupation: _____

Phone: Home: _____Cell:_____Work: _____

Other Info: _____

_____

321 4th St. N, downtown Fargo, ND P: 701-235-6075 F: 701-239-0140
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New Patient Questionnaire

Patient Name: _____ Date: _____

Our practice is committed to providing each of our patients with highly individualized care consistent with their specific needs, wants, and values. By answering the following questions candidly, you will help us to better understand your dental concerns and expectations. Your answers are for our records only and will remain confidential.

1). Does dental treatment make you nervous? No slightly Moderately Extremely

2). Have you ever had any serious trouble associated with previous dentistry? Yes No

3). How often do you use the following?

Toothbrush (manual or electric) _____

Dental Floss _____

Other oral hygiene device _____

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

Orthodontic treatment	Yes	No	Loose Teeth	Yes	No
Clicking/popping jaw	Yes	No	Teeth sensitive to hot, cold, sweets	Yes	No
Difficulty opening/closing jaw	Yes	No	Teeth sensitive to chewing	Yes	No
Clenching or grinding	Yes	No	Bleeding or sore gums	Yes	No
Shifting or change in bite	Yes	No	Unpleasant taste or bad breath	Yes	No

5). With regards to your sleep habits, do you or have you…..

Feel rested when you wake up?	Yes	No
Been told that you snore when you sleep?	Yes	No
Have difficulty falling or staying asleep?	Yes	No

6). The following best describes my attitude toward dental health?

I have always done what was recommended for my dental health.

I have not always done what dentist have recommended to me.

I rarely go to the dentist, not much interest in dental work.

7). Should I need treatment, my desire would be best described as:

Wanting the best restorations possible that will be the most conservative and give the longest life.

Wanting the least expensive restoration that will get me by for now.

8). Do you like the color of your teeth? Yes No

9). Do you consider your existing fillings or dental work unattractive? Yes No

10). What would you like to change most in the appearance of your teeth or your smile?

_____

11). What are some questions about dentistry and your oral health that you have never had adequately answered?

_____

_____

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What You Need to Know About Your Insurance

If you have dental needs beyond healthy cleanings, your care will require an investment beyond what your insurance covers.

Your insurance will assist you very well in the maintenance of your dental health, but it was never designed to restore health when significant breakdown or disease is present in your mouth. Unlike medical and other types of insurance, dental insurance does not typically protect against extraordinary and significant needs. The procedures best covered by most dental policies are not only predictable, but expected, such as routine exams, x-rays, healthy cleanings, etc.

Another common misconception is that dental insurance covers what you need, because it implies that if it isn't covered you don't need it. This is not the case for most individuals.

Your dental insurance is a contract between you and/or your employer and a dental insurance company. We strongly recommend for you to reach out to your insurance provider with any questions about your coverage.

Patient or Guarantor's Signature _____ Date _____

a: 321 4th Street N., Fargo, ND p: 701.235.6075 w: archdentalfargo.com e: info@archdentalfargo.com

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be 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 Guardian:

X Date:_____