ACHARYA
PERIODONTICS & DENTAL IMPLANTS

Patient Registration Form

Patient Information

Name: _____ Gender: _____ Male _____ Female
(First) (Last)
Address: _____ City: _____
State: _____ Zip Code: _____
Home Phone:_____Mobile: _____Work Phone: _____
Email Address: _____Appt. Confirmation Preference: Call: ___ Text:_____ E-Mail: _____
Social Security Number: _____-_____-_____ Date of Birth: _____
Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Minor ____ Student ____
Person to Contact in Case of Emergency: _____
Relationship to Patient: _____ Phone Number: _____

Dental Insurance Information (policy holder, if someone other than yourself)

Insurance Company: _____ Policy/ID #: _____
Name of Insured: _____ Relationship to Patient: _____
Insured Birthdate: _____ SSN for Insured: _____
Name of Employer: _____ Employer Phone #: _____

Dental History

Name of General Dentist: _____ Date of Last Visit: _____
May We Request Your Dental Records: _____ Purpose of Today's Visit: _____
Have You Been Diagnosed With Periodontal Disease: _____ If yes, When: _____
Have You Received Periodontal Treatment: _____ If yes, Where: _____
Do You Wear Dentures or Partials: _____ Do You Have Dental Implants: _____
Have You Had Orthodontic Treatment: _____ Do You Clench/Grind Your Teeth: _____

Medical History

Physician's Name: _____ Phone: _____
Pharmacy Preference: _____ Phone: _____
Are You Required to Take Pre-Medication Prior Dental Treatment: _____
Are You Currently Taking Any Medications: _____ If so, please list: _____
_____
Do You Have Any Allergies: _____ If so, please list: _____
Have you been diagnosed with osteoporosis/osteopenia

Medical History Continued

Please Check All That Apply:

- Acid Reflux
- AIDS/HIV (Circle one)
- Allergies
- Anemia
- Arthritis
- Artificial Joint_____
- Asthma
- Bisphosphonate Use
- Blood Disease
- Blood Thinner
- Cancer_____
- Cardiac Pacemaker
- Chemotherapy_____
- Currently Pregnant
- Diabetes I, II
- Emphysema
- Epilepsy
- Glaucoma/Cataracts
- Heart Attack_____
- Heart Disease
- Heart Murmur
- Heart Surgery_____
- Hepatitis A, B, C or D
- High Blood Pressure
- High Cholesterol
- Hypoglycemia
- Kidney Disease
- Latex Allergy
- Liver Disease
- Low Blood Pressure
- Migraine Headaches
- Mitral Valve Prolapse
- Neurological Disorder
- Organ Transplant
- Psychiatric Treatment
- Prostate Problems
- Radiation_____
- Respiratory Problems
- Rheumatic Fever
- Sinusitis
- Stroke
- Substance Abuse
- Swollen Ankles
- Thyroid Disease
- Smoke Circle what applies Tobacco Vape Marijuana
- Tuberculosis
- Ulcers
- Other:_____

Consent for Dental Photography

I authorize Acharya Periodontics & Dental Implants to take and use photographs and/or videos for educational, informational, and marketing purposes. Images may be used, but are not limited to, Acharya Periodontics & Dental Implants' social media accounts, website, seminars, etc. I understand that if the photographs and/or videos are used, my name and other identifying information will be kept confidential. After reading the explanation above, I authorize Acharya Periodontics & Dental Implants to take and use any photographs or media in any Acharya Periodontics & Dental Implants presentation or publication including electronic internet material.

By initialing here, I authorize photos to be taken _____

Authorization

I certify that I have read, and I understand the questions above. I acknowledge that my questions, if any, about any of the inquires above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff responsible for any errors or omissions on this form. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I must continue to visit a general dentist while under periodontal care. To best service my account, I understand that I may be contacted at any telephone number associated with my account, including wireless numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automatic dialing device, as applicable.

Patient Signature (parent/guardian if minor): _____ Date: _____