Please bring these completed forms with you to your appointment on _____

Dr. Bradley J. Shuder, DDS, LLC

Patient Registration

Patient Name: _____ Birth Date: _____ Social Security:_____

Patient Information

Street Address:_____

City:_____ State:_____ Zip:_____

Home #: _____

Work #:_____

Cell #:_____

Email Address: _____

Gender: ☐ Male ☐ Female

Employer: _____

Occupation: _____

Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced ☐ Partnered

Spouse/Partner Name: _____

Work #:_____

Cell #:_____

Emergency Contact (please specify someone who does not live in your household)

Name:_____ Relationship to Patient: _____

Home #:_____ Work #:_____

Cell #:_____ Whom may we thank for referring you? _____

Responsible Party/Insurance Subscriber Information (if other than patient)

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Birth Date: _____

Work #:_____ Social Security #:_____

Cell #:_____

Employer: _____ Group #: _____ ID #: _____

Insurance Company: _____ Phone #: _____

Insurance Claims Address: _____

I certify that I/ my dependents have insurance coverage and assign to Dr. Shuder all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred including treatment, missed appointment charges, and any collection fees. I authorize my signature on all insurance submissions and give permission to Dr. Shuder and staff to disclose information necessary to obtain payment for services rendered.

Signature of Responsible Party:_____**Date:**_____

OR

I do not currently have insurance coverage and understand that I am financially responsible for all charges incurred including treatment, missed appointment charges, and any collection fees.

Signature of Responsible Party:_____**Date:**_____

SEE BACK →

Dr. Bradley J. Shuder, DDS, LLC

Patient Registration

Medical History

Date of last dental visit: _____ Former Dentist: _____

How often do you brush? _____ How often do you floss? _____

PLEASE CHECK ALL THAT APPLY:

Abnormal bleeding after extraction ☐	Dry mouth ☐	Cigarette/ tobacco habit ☐
Mouth breathing ☐	Pregnant or nursing ☐	Fingernail biting ☐
Orthodontic treatment ☐	Jaw pain or tiredness ☐	Grinding teeth ☐
Clicking or popping in jaw ☐	Periodontal treatment ☐	Taken diet pill Phen-Fen or Redux ☐

Are you on a special diet? Yes ☐ No ☐ Explain: _____

Do you have any learning, communication or behavioral issues? Yes ☐ No ☐ Explain: _____

Have you traveled outside of the country in the past 6 months? Yes ☐ No ☐ Explain: _____

Are you under a physician's care now? Yes ☐ No ☐ Explain: _____

If Yes, Physician's Name: _____ Phone Number : _____

Have you ever been hospitalized or had a major operation? Yes ☐ No ☐ Explain: _____

Are you taking any medication for Osteoporosis? Yes ☐ No ☐ Explain: _____

Do you take any blood-thinning medications? Yes ☐ No ☐ Explain: _____

Have you ever been told to pre-medicate prior to dental treatment by any physician or dentist? Yes ☐ No ☐

Are you allergic to any of the following?

Aspirin ☐ Latex ☐ Codeine ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa ☐ Other: _____

PLEASE CHECK ALL THAT APPLY:

AIDS/HIV ☐	Circulatory problems ☐	Herpes ☐	Osteoporosis ☐
Anaphylaxis ☐	Congenital heart disease ☐	High blood pressure ☐	Rheumatic fever ☐
Artificial joints ☐	Diabetes ☐	Hypoglycemia ☐	Scarlet fever ☐
Artificial heart valve ☐	Epilepsy or seizures ☐	Kidney disease ☐	Stroke ☐
Asthma ☐	Heart murmur ☐	Liver disease ☐	Tuberculosis ☐
Blood disease/transfusion ☐	Heart pace maker ☐	Low blood pressure ☐	
Breathing problems (not asthma) ☐	Hemophilia ☐	Mitral valve prolapse ☐	Other: _____
Cancer treatment ☐	Hepatitis type _____ ☐		

Please list any medications you are currently taking, reason, strength (mg), and dosage (times per day):

_____

_____

_____

_____

_____

_____

_____

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: _____ Date: _____