REGISTRATION **JODI SLOOTSKY, DMD**

PATIENT INFORMATION

Name ______________________________ Cell Phone # (___) ___-____
Last First Middle

Address ______________________________ Home Phone # (___) ___-____

City ______________ State _____ Zip ________ Work Phone # (___) ___-____

Sex ☐M ☐F Birth Date __-__-__ SSN ___-___-____ Status: ☐Single ☐ Married ☐ Divorced

Email Address ______________________________ Occupation ______________

Communication preference(s): ☐ Phone ☐ Text ☐ Email Employer ______________

How did you hear about us? ☐ Our Website ☐ Internet Search ☐Insurance Directory ☐ Phone Book

☐ Friend or Relative ______________ ☐ Other (specify) ______________

Emergency Contact Person ______________________________ Phone # (___) ___-____

PRIMARY DENTAL INSURANCE

Dental Insurance Plan Subscriber ______________________________
Last First Middle

Relation to Patient ______________ Birth Date __-__-__ SSN ___-___-____

Address (If not patient) ______________________________ Phone # (___) ___-____

City ______________ State ________ Zip ________

Person Responsible Employed by ______________ Occupation ______________

Insurance Company ______________ Insurance Phone # (___) ___-____

Ins. Claims Address ______________________________

Group # ______________ Subscriber ID # ______________

Names of other dependents covered under this plan ______________

SECONDARY DENTAL INSURANCE

Dental Insurance Plan Subscriber ______________________________
Last First Middle

Relation to Patient ______________ Birth Date __-__-__ SSN ___-___-____

Address (If not patient) ______________________________ Phone # (___) ___-____

City ______________ State ________ Zip ________

Person Responsible Employed by ______________ Occupation ______________

Insurance Company ______________ Insurance Phone # (___) ___-____

Ins. Claims Address ______________________________

Group # ______________ Subscriber ID # ______________

Names of other dependents covered under this plan ______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have dental insurance coverage with the above company(ies) and assign directly to Dr. Jodi Slootsky all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. I hereby authorize this office to release all information necessary to secure payment for services rendered. I also authorize the use of this signature on all insurance submissions.

Relation (if patient is a minor) **Signature of Responsible Party** **Date**

DENTAL & MEDICAL HISTORY

JODI SLOOTSKY, DMD

DENTAL HISTORY

Reason(s) For Today's Visit ____________________

Former Dentist / Address ____________________

Date of Last: Dental Exam __________ Dental X-rays __________ Dental Cleaning __________

Please **Check** all boxes that apply:

☐ Anxiety getting dental treatment	☐ Unhappy with your Smile	☐ Interested in Whiter Teeth
☐ Bad breath	☐ Grinding / Clenching teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Gum disease	☐ Sensitivity to cold
☐ Clicking or popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity to biting
☐ Food collection between teeth	☐ Sores or growths in mouth	☐ Sensitivity to sweets

How often brush?__________ How often floss? __________ Use Mouth Rinse (brand)?__________

MEDICAL HISTORY

Physician's Name / Address ____________________ Date of last visit __________

Have you had any serious illness / Hospitalization / Operation (dates)? ____________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please **Check** all conditions you currently have or have had in the past:

☐ AIDS	☐ Cortisone Treatments	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis / Rheumatism	☐ Cough up Blood	☐ HIV Positive	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy / Seizures	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Swelling of Feet /Ankles
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Bone Loss	☐ Headaches	☐ Nervous Condition	☐ Tobacco Habit
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Problem (Describe)	☐ Psychiatric Care	☐ Tuberculosis, TB
☐ Chemotherapy	__________	☐ Radiation Treatment	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease

☐ Take **Bisphophonates** meds in **Past** or **Present**: ☐ Actonel ☐ Boniva ☐ Fosamax ☐ Skelif ☐ Didrone ☐ Other

MEDICATIONS

List of medications you are currently taking:

__________ __________

__________ __________

__________ __________

__________ __________

Pharmacy & Phone # __________

ALLERGIES

☐ **No Known Drug Allergies**	☐ Penicillin
☐ Aspirin	☐ Sleeping Pills
☐ Codeine / Narcotics	☐ Sulfa Drugs
☐ Erythromycin	☐ Clindomycin
☐ Local Anesthetics	☐ Other __________
☐ Barbiturates / Sedatives	__________

CONSENT AND SIGNATURE

I hereby give permission to Dr. Jodi Slootsky and her staff to perform dental treatments on myself (or my dependent minor if applicable). The above information is accurate, true and complete to the best of my knowledge. I will not hold Dr. Jodi Slootsky or her staff responsible for any knowing or unknowing errors or omissions that I may have made on this form.

Signature (Parent or Guardian if minor) ____________________ **Date** __________