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## PATIENT REGISTRATION FORM

**Patient Name** \_\_\_\_\_

Last name	First name	Middle Initial
Street	Apt#	City/State
( ) - ( ) -	( ) -	Zip Code
Home Phone #	Work Phone #	Cellular Phone #
/ /	M S D W O	Social Security. #
Date of Birth	M F	Occupation
	Sex	Employer

### Whom may we thank for referring you?

**Do you have insurance?      Yes      No**

**Person responsible for account (if other than patient)**

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Pager \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

**Person to contact in case of an emergency** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Financial Responsibility Agreement**

In consideration of treatment rendered the above named Patient, I accept full financial responsibility. Insurance forms will be completed as convenience to the Patient; however, payment to the doctor is expected at the time services are rendered, unless other arrangements are made in advance. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection cost, interest of 21% APR, court costs and reasonable attorney fees.

Signature \_\_\_\_\_ Patient or Parent/Guardian if minor \_\_\_\_\_ Date \_\_\_\_\_

### DENTAL HISTORY

Why are you seeking dental care? Routine check-up? YES NO Other \_\_\_\_\_  
 Name & address of previous dentist \_\_\_\_\_  
 When was your last dental visit? \_\_\_\_\_ What was done at the visit? \_\_\_\_\_  
 When was your last dental cleaning? \_\_\_\_\_ Do your gums bleed? YES NO  
 How often do you brush your teeth? \_\_\_\_\_ How often do you floss your teeth? \_\_\_\_\_  
 Have you had any gum surgery or gum treatment in the past? YES NO  
 Do you smoke? YES NO If yes, \_\_\_\_\_ packs/day for \_\_\_\_\_ years  
 Do you have any lumps, sores, or swollen areas in your mouth? YES NO  
 Have you had any teeth removed? YES NO If yes, when were they removed? \_\_\_\_\_  
 Do you have partial or full dentures? YES NO If yes, how old are they? \_\_\_\_\_  
 Are any of your teeth sensitive to: (circle one) hot cold pressure sweets  
 Do you want to save your teeth? YES NO If no, why? \_\_\_\_\_

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Are you happy with appearance of your teeth? YES NO Do you want to have your teeth whitened? YES NO

**MEDICAL HISTORY**

Physician's name, address, and phone \_\_\_\_\_

Have you been seen by a physician in the past 2 years? YES NO If yes, why? \_\_\_\_\_

Have you been hospitalized in the past 5 years? YES NO If yes, why? \_\_\_\_\_

Have you ever had any operations or surgery? YES NO IF yes, what condition? \_\_\_\_\_

Have you ever had prolonged or excessive bleeding required special treatment? YES NO

**List all prescription, over the counter and herb medications that you are taking and reason you are taking them** \_\_\_\_\_

**Do you have allergic or other unusual reactions to the following? YES NO If yes, circle:**

**Penicillin Aspirin Codeine Sulfa Dental Anesthetics (novocaine, lidocaine, procaine, xylocaine)**

**Others (please list):** \_\_\_\_\_

**Have you ever had any of the diseases or conditions list below? (Please circle YES or NO):**

- |                                  |        |                                     |        |
|----------------------------------|--------|-------------------------------------|--------|
| Heart Problems.....              | YES NO | Sinus Trouble.....                  | YES NO |
| - mitral valve prolapse.....     | YES NO | Allergies or Hives.....             | YES NO |
| - heart murmur.....              | YES NO | Diabetes.....                       | YES NO |
| - artificial heart valve.....    | YES NO | Cancer or Tumor.....                | YES NO |
| - heart pacemaker.....           | YES NO | Radiation or Cobalt Tx.....         | YES NO |
| - congenital heart lesions.....  | YES NO | Chemotherapy.....                   | YES NO |
| - heart surgery.....             | YES NO | Arthritis.....                      | YES NO |
| - heart disease or attack.....   | YES NO | Cortisone Medications.....          | YES NO |
| - heart failure.....             | YES NO | Glaucoma.....                       | YES NO |
| - angina pectoris.....           | YES NO | Hepatitis.....                      | YES NO |
| Artificial Joint.....            | YES NO | Yellow Jaundice.....                | YES NO |
| Rheumatic Fever.....             | YES NO | Blood Transfusion.....              | YES NO |
| High Blood Pressure.....         | YES NO | Alcohol or Drug Addiction... YES NO |        |
| Anemia.....                      | YES NO | Hemophilia.....                     | YES NO |
| AIDS (HIV+).....                 | YES NO | Veneral Disease.....                | YES NO |
| White or Blue Patches in Mouth.. | YES NO | Genital Herpes.....                 | YES NO |
| Stroke.....                      | YES NO | Cold Sores or Fever Blisters        | YES NO |
| Kidney Trouble.....              | YES NO | Epilepsy or Seizures.....           | YES NO |
| Ulcers.....                      | YES NO | Fainting or Dizzy Spells.....       | YES NO |
| Emphysema.....                   | YES NO | Nervous Disorders.....              | YES NO |
| Enlarged Glands or Lymph Node    | YES NO | Psychiatric Treatment.....          | YES NO |
| Chronic Cough.....               | YES NO | Sickle Cell Disease.....            | YES NO |
| Tuberculosis (TB).....           | YES NO | Thyroid Disease.....                | YES NO |
| Asthma.....                      | YES NO |                                     |        |
| Hay Fever.....                   | YES NO |                                     |        |

Do you have any other disease or condition not mentioned above?.....YES NO

If yes, list: \_\_\_\_\_

**WOMEN ONLY:** Are you pregnant? YES NO If yes, due date: \_\_\_\_\_

Are you taking birth control pills? YES NO

**To the best of my knowledge, all of the information provided on both sides of this registration form is correct**

**Signature of Patient, Parent, or Legal Guardian**

**Date**

**Reviewing Doctor**