welcome

We're so glad you're here!

CEDAR BLUFF DENTISTRY NEW PATIENT REGISTRATION

It is our goal to provide exceptional dental care to our patients! We love what we do and want our patients to feel confident that they will receive the best of what dentistry has to offer!

Patient name:_____ Preferred name: _____ Date of birth: _____

Name of responsible party: _____ Relationship to patient: _____

Home number: _____ Cell phone number: _____

Mailing address: _____

Email: _____ How did you hear about our practice? _____

DENTAL AND MEDICAL INSURANCE

I authorize Cedar Bluff Dentistry to obtain benefits from dental or medical insurance when applicable. I hereby authorize and direct my insurance carrier(s), including dental, private medical insurance and any other health/medical plan, to issue payment directly to Cedar Bluff Dentistry. Insurance estimations are not a guarantee of payment, and the final responsibility for payment for all services rendered is that of the patient. Patient/Guardian Signature: _____

GENERAL POLICIES

I certify that I have been presented with, and fully understand, the following Cedar Bluff Dentistry Policies:

Notice of Privacy Practices HIPPA **Financial Policy** **Cancellation Policy**

By signing, I understand that I am agreeing to the terms and conditions set forth.
If you would like copies of any of the policies you may request them or visit our website at www.cedarbluffdentistry.com

Patient/Guardian Signature: _____ Date: _____

I authorize Cedar Bluff to use any photos or x-rays of my teeth, mouth or gums for use in patient education, publications or social media. There will be no identifying information attached to the photos used.

Patient/Guardian Signature: _____

We want you to feel as relaxed as possible during your visit. If we may provide you with any of the following comfort items please let us know.

Pillow Blanket Bluetooth Headphones

Dental and Health History Continued on Next Page

We are here to serve you! Please help us focus our exam by answering the following questions.

GENERAL HEALTH

To the best of your memory, when was your last dental cleaning and check up? _____
Please describe any past trauma involving your teeth: _____

Have you been diagnosed with periodontal disease? Yes No
Have you been told you have, or think you have, cavities? Yes No
Do you have loose teeth? Yes No
Do you experience bleeding gums? Yes No
Do you feel you experience bad breath? Yes No

How often do you brush your teeth?
Never Rarely Daily 2x/Day

How often do you floss your teeth?
Never Rarely Daily 2x/Day

Please select any of the following symptoms or conditions that apply to you:

- ○ Pain with Teeth
- ○ Broken Teeth
- ○ Teeth with Cracks
- ○ Sensitive to: Hot Cold Biting Other
- ○ Frequent Gastric Reflux
- ○ Frequently consume sugary drinks
- ○ Wisdom Teeth Extracted
- ○ Missing Teeth ---- If yes, are you interested replacing teeth with dental implants? Yes No

BITE AND JAW HEALTH

Have you been treated for temporomandibular disorder (TMD or TMJ)? Yes No
Have you noticed or been told you clench or grind teeth at night or any other time? Yes No
Do you have a comfortable bite? Yes No
Does your jaw joint click or pop? Yes No
Do your teeth feel sore when eating? Yes No
Have you worn a bite or night guard in the past? Yes No
Do you ever have sore jaws or biting muscles? Yes No
Do your teeth feel sore in the morning? Yes No
Have you ever experienced lock jaw? Yes No
Do you currently wear a bite guard? Yes No
If yes, was the guard fabricated in a dental office? Yes No When was it fabricated? _____

SMILE ANALYSIS

Have you had orthodontic treatment (braces)? Yes No
Do you like the appearance of your teeth? Yes No
Are you interested in whitening your teeth? Yes No
Are you interested in straightening your teeth with Invisalign? Yes No
Do you have fillings or crowns you do not like the appearance of? Yes No
Are you interested in a Smile Makeover? Yes No

SLEEP HEALTH

Do you have issues with snoring? Yes No
Are you frequently tired during the day? Yes No
Do you or have you ever worn a CPAP? Yes No
Are you interested in an in-home sleep study? Yes No
Do you awake feeling rested? Yes No
Have you been diagnosed with Sleep Apnea? Yes No
If yes, do you have issues wearing your CPAP? Yes No

- ○ It is our pleasure to offer oral sedation to help ease your anxiety and minimise discomfort during dental procedures. Please select the box if you are interesting in learning more about sedation.

- ○ I am interested in learning more about financing options that may be available to assist with the completion of my dental needs.

Please list any other concerns or notes for Dr. Bayer to be aware of: _____

Patient Signature: _____ Date: _____