Michael S. Singleton, D.D.S., PLLC
1081 North Ann Arbor Street
Saline, MI 48176
Phone: 734-429-7415
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Patient Registration

Date_____

Last Name _____First Name_____ DOB _____

Prefers To Be Called By _____Male ____ Female ____

Address _____ City, State _____ Zip _____

Phone Number – Home _____ Cell _____ Work _____

Email Address _____ Emails OK? _____ Texts OK? _____

Emergency Contact _____ Emergency Contact Phone Number _____

Occupation _____ Employer Name _____

SSN _____

How did you find our office? _____

Person Responsible for Dental Investment _____ Phone Number _____

Name of PRIMARY Subscriber _____ SSN _____ DOB _____

Subscriber Employer _____ Ins. Co. _____ Ins. Co. Phone Number _____

Relationship to Patient _____

Name of SECONDARY Subscriber _____ SSN _____ DOB _____

Subscriber Employer _____ Ins. Co. _____ Ins. Co. Phone Number _____

Relationship to Patient_____

WELCOME TO OUR OFFICE

We are pleased you have chosen our professional staff to assist you with your dental care. We appreciate the trust you have placed in us and we will honor it by providing you with the very finest dental care. Our practice is known for its friendly, highly trained staff, breadth of services and state-of-the-art dental care equipment.

Our goal is to help you maintain a healthy and attractive smile. We know people want to keep their teeth healthy for a lifetime. We believe the best way to achieve healthy teeth and gums is through preventative dentistry. This approach is a shared responsibility between you, the patient, and your dental care providers.

In addition to preventative dentistry, our staff also offers a wide variety of services. These include: implants, crowns, bridges, partial and complete dentures, root canals, extractions, braces, cosmetic services (whitening, bonding, porcelain veneers and tooth colored fillings), a highly successful non-surgical approach to periodontal therapy and oral surgery. For the fearful or special needs patient, our staff provides sleep dentistry.

Thank you for your confidence in our office.

Michael S. Singleton, D.D.S., PLLC

PATIENT MEDICAL HISTORY

Patient Name: Birth Date: Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Have you ever had a serious head or neck injury?	Yes	No	If yes
Are you taking any medications, pills, or drugs?	Yes	No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	

Women: Are you…

Pregnant / Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Sulfites

Do you use controlled substances?	Yes	No	If yes
Other?			If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Cancer	Yes	No
Bruise Easily	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No	Chemotherapy	Yes	No
Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No	Chest Pains	Yes	No
Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No	Cold Sores/Fever Blisters	Yes	No
Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No	Congenital Heart Disorder	Yes	No
Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No	Convulsions	Yes	No
Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No			
Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Yellow Jaundice	Yes	No			

Have you ever had any serious illness not listed? Yes No If yes

Comments:

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:

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Last Name _____ First Name _____ DOB _____ Date _____

DENTAL HISTORY QUESTIONS:	YES	NO
How often do you brush your teeth?		
How often do you floss?		
Do your gums bleed or hurt when brushing?		
Does food catch between your teeth?		
Do you have difficulty chewing?		
Do you avoid any part of the mouth while brushing?		
Have you ever had any teeth removed?		
How long have these teeth been missing?		
Do you feel you will eventually wear artificial dentures?		
Have you ever had a reaction to local anesthetic?		
Are your teeth sensitive to:		
• Heat?		
• Cold?		
• Sweets?		
• Biting Pressure?		
Have you noticed gum swelling around any teeth?		
Do you have any unpleasant tastes or odors in your mouth?		
Problems of the jaw:		
• Clicking of the jaw?		
• Pain (joints, ear, neck, head)?		
• Difficulty opening or closing?		
• Do you clench or grind your teeth while awake or asleep?		
Are you dissatisfied with your teeth and their appearance? If so, please describe:		
Are you deeply concerned about the finances required to restore you teeth to excellent dental health?		
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?		
Do you have any fears?		
When was your last dental appointment?		
When was your last dental cleaning?		
Have you ever been told you have Periodontal Disease or undergone treatment for it?		
Have you ever been told to take a premedication prior to dental treatment?		
Why did you leave your last dentist?		
What is your present dental problem?		
Is there anything else about having dental treatment that you would like us to know?		

CONSENT FOR TREATMENT

I hereby authorize Dr. Singleton and his staff to take x-rays, study models, photographs, and other diagnostic aids that are deemed appropriate for diagnostic purposes. Upon such diagnosis, I authorize Dr. Singleton and his staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

FINANCIAL AGREEMENT

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. If you have dental insurance, our office can submit charges to your insurance carrier. Co-payments and deductibles, or payment in full, is due at the time service is rendered. We accept cash, check, MasterCard, Visa, Discover, American Express and CareCredit. I understand that I am responsible for payment of all services, regardless of any insurance company's arbitrary determination of payment, and I agree to this policy.

ACKNOWLEDGEMNT OF RECEIPT OF PRACTICE'S NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other related federal laws, I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. I have been given the opportunity to review and ask any questions I may have regarding this Notice.

Patient/Guardian Signature _____ Date _____