Family Dentistry
Dr. Indra Sidhu, DDS & Associates
595 Main St Ste 237 Laurel, MD 20707
208 Crain Hwy SW Glen Burnie, MD 21061

Patient Registration Record Date: ___/___/___

Note: if patient is a minor, parent / guardian must complete and sign form!

Email: _____

Patient's name: _____ ☐ Male ☐ Female
Last First Middle

Birthdate : ____/____/_____ Social security number: _____-_____-_____ Driver's License #: _____
Month Day Year

Home phone #: (_____)_____-_____ Cell #: (_____)_____-_____ Work #: (_____)_____-_____ Ext: _____

Home Address: _____
Street City State Zip

Mailing Address: _____
(if different from above) Street City State Zip

Occupation: _____ Employer: _____ Employer phone #: (____)____-_____

Employer Address: _____
Street City State Zip

Spouse's name: _____ Spouse's Occupation: _____ Employer: _____

Patient referred by: _____ Patient's family physician: _____

Person responsible: _____ ☐ Male ☐ Female
for account (if not self) Last First Middle

Birthdate : ___/___/___ Social security number: ____-___-_____ Driver's License #: _____
Month Day Year

Home phone #: (____)____-_____ Cell #: (____)____-_____ Work #: (____)____-_____ Ext: _____

Insurance information:
Insurance company: _____ Group number: _____ ID number: _____

Policy holder: _____ Birthdate : ___/___/____ SSN: _____-_____-_____
Last First Month Day Year

Medicare number: _____ Medicaid number: _____ MA number: _____

Is this a legal case? ☐ Yes ☐ No Is this a worker compensation case? ☐ Yes ☐ No

Date of injury/accident: ___/___/___ Employer at time of injury/accident: _____

Auto insurance co: _____ Claim #: _____ Policy #: _____ Phone #: (____)____-_____

Attorney's name: _____ Phone #: (____)____-_____
Last First Middle

Authorizations:

I, _____, hereby authorize Indra Sidhu, DDS & Associates to apply for benefits on my behalf for services rendered to me (or minor child) and request that payment is made by _____ insurance company and that payment be sent directly to Indra Sidhu, DDS & Associates. I understand that this does not relieve me of my primary responsibility to pay for the services rendered to me (or my minor child). If my account is turned over for collection, I agree to pay 25% collection fees. If suit is filed, I agree to pay 33.3% attorney's fees, court costs, and other expenses incurred as a result of said collection. The undersigned agrees that if suit should be filed, venue (location of suit) will be in Prince George's County or Anne Arundel Counties, Maryland. Venue in any other counties being hereby waived. It is further understood that overdue accounts will be charged interest at the rate of 18% (1.5% per month). I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of my information relating to any claim for benefits to any appropriate third party by fax, mail, or electronically. I permit a copy of this authorization to be used in place of the original. The authorization may be revoked by me at anytime in writing.

Date: _____ Patient's / Responsible party's signature: _____

Patient's name: _____ Birthdate : ____/____/_____

Physician's name: _____ Physician's phone #: (____)____-____ When was your last physical exam? _____

Physician's Address:_____
Street City State Zip

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, why? _____

Do you take any of the following?

Y N Acetaminophen
Y N Alcohol abuse
Y N Antibiotics
Y N Antihistamines
Y N Aspirin
Y N Bisphosphonates
Y N Blood thinners
Y N Blood pressure medication
Y N Cold remedies
Y N Digitalis / Heart medication
Y N Diabetes drugs / Insulin
Y N Nitroglycerin
Y N Recreational drugs
Y N Steroids / Cortisone
Y N Thyroid medicine
Y N Tranquilizers
Y N Tobacco (smoking / chewing)

Please list any prescription / over-the-counter drugs you are taking if not listed above: _____

Do you have or have you experienced the following?

Y N Heart disease
Y N Asthma
Y N Pacemaker
Y N Artificial valves
Y N Artificial joints
Y N Rheumatic fever
Y N Heart murmurs
Y N Stroke
Y N High blood pressure
Y N Low blood pressure
Y N Liver problems
Y N Kidney problems
Y N Diabetes
Y N Asthma
Y N Seizures / Epilepsy
Y N Venereal disease
Y N HIV
Y N AIDS
Y N Hepatitis
Y N Tuberculosis
Y N Psychiatric problems
Y N Abnormal bleeding
Y N Anemia
Y N Cancer
Y N Chicken pox
Y N Difficulty breathing
Y N Radiation treatment
Y N Tuberculosis
Y N Ulcers
Y N Sickle cell disease

Please list any health concerns not mentioned above:
_____

For women:

Are you taking birth control pills? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Are you pregnant? ☐ Maybe ☐ Yes ☐ No
Week #: _____

Are you allergic to any of the following?

Y N Aspirin
Y N Barbiturates
Y N Codeine
Y N Dental Anesthetic
Y N Erythromycin
Y N Jewelry / metals
Y N Latex
Y N Penicillin
Y N Sedatives
Y N Sulfa drugs
Y N Tetracycline
Y N Other

Please list any additional drugs/materials that cause allergic reactions: _____

Please check this box if you would like to speak to the doctor privately about any problems ☐

Purpose of initial visit: _____

_____

Are you aware of a problem? _____

When was your last dental visit? _____

What was done at that time? _____

Previous dentist's name: _____

When was the last time your teeth were cleaned? _____

Date of last dental X-rays: _____

Have you made regular dental visits? Y N
Have you lost any teeth? Y N
Have you had any teeth removed? Y N
How have they been replaced? Fixed bridge Complete denture Implant Removable partial
Are you unhappy with the replacement? Y N
Would you like to know about permanent replacements? Y N
Have you ever had any problems or complications with previous dental work? Y N
If yes, please explain _____
Do you clench or grind your teeth? Y N
Does your jaw click or pop? Y N
Does food get caught in your teeth? Y N
Are any of your teeth sensitive? Hot Cold Sweets None
Do your gums bleed or hurt? Y N
If yes, when do they hurt? _____
How often do you brush your teeth? _____
When do you brush your teeth? _____
Do you use dental floss? Y N
How often? _____
Are any of your teeth loose, shifted, or chipped? Y N

Have you experienced soreness in the facial muscles or around the ear? Y N
Do you have frequent headaches, neck aches, or shoulder aches? Y N
Are you unhappy with the appearance of your teeth? Y N
How do you feel about your teeth in general? Y N
Do you feel your breath is offensive at times? Y N
Have you ever had gum treatment or surgery? Y N
If so, what, when, and where? _____
Have you had orthodontic work? Y N
Have you ever had an unpleasant dental experience? Y N
Please explain _____
Is there anything you dislike about the dentist? Y N
If yes, please explain _____
Do you have any dental concerns or questions you would like answered? _____

I certify that the above information is complete and accurate

Patient signature: _____ Date: _____

Dentist signature: _____ Date: _____