

DENTAL REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____ City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS # _____

Occupation _____

Spouse's Employer _____

Spouse's Employer Phone _____

Whom may we thank for referring you? _____

And Phone Number _____

2

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ 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 paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. If the account is turned over to an outside agency, I will be responsible for collection and attorney fees.

Responsible Party Signature _____

Date _____

3

NO DENTAL INSURANCE ASSIGNMENT AND RELEASE

Who is responsible for this account? _____ Relationship to Patient _____

Responsible party birth date _____ SS# _____

ASSIGNMENT AND RELEASE

I, the undersigned (or my dependent) am fully aware that I am responsible for all charges.

If the account is turned over to an outside agency, I will be responsible for collection and attorney fees.

Responsible Party Signature _____

Date _____

4

PHONE NUMBERS

Home _____ Work _____ Ext. _____ Spouse's Work _____

Cell _____ E-Mail _____

Best time and number to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

5

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following

- Bad breath Yes No
- Bleeding gums Yes No
- Blisters on lips or mouth Yes No

- Burning sensation on tongue Yes No
- Chew on one side of mouth Yes No
- Cigarette, pipe, or cigar smoking Yes No
- Clicking or popping jaw Yes No
- Dry mouth Yes No
- Fingernail biting Yes No
- Food collection between the teeth Yes No
- Foreign objects Yes No
- Grinding teeth Yes No
- Gums swollen or tender Yes No
- Jaw pain or tiredness Yes No
- Lip or cheek biting Yes No

- Loose teeth or broken fillings Yes No
- Mouth breathing Yes No
- Mouth pain, brushing Yes No
- Orthodontic treatment Yes No
- Pain around ear Yes No
- Periodontal treatment Yes No
- Sensitivity to cold Yes No
- Sensitivity to heat Yes No
- Sensitivity to sweets Yes No
- Sensitivity when biting Yes No
- Sores or growths in your mouth Yes No
- How often do you floss? _____
- How often do you brush? _____

6

HEALTH HISTORY

It is your responsibility to update us of any and all changes in your medical history.....i.e. Pregnancy, Heart Conditions, Diabetes, Medication changes, etc.

Physician's Name _____ Physician's Phone Number _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | |
|---|--|--|
| AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally; with extractions or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody <input type="checkbox"/> Yes <input type="checkbox"/> No | Muscular Dystrophy <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Women: |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Due date _____ |
| Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you nursing <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | |

OTHER: _____

| MEDICATIONS | ALLERGIES | UPDATED |
|--|--|---|
| List medications you are currently taking: _____ _____ _____ Are you currently under pain management? <input type="checkbox"/> Yes <input type="checkbox"/> No Pharmacy Name _____ Phone _____ | <input type="checkbox"/> Aspirin <input type="checkbox"/> Barbiturates (Sleeping pills) <input type="checkbox"/> Codeine <input type="checkbox"/> Iodine <input type="checkbox"/> Latex <input type="checkbox"/> Food Allergies <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____ | Patient Name _____ _____ Date _____ |