DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date:_____
SSN#_____
Patient Name_____
Last Name
_____
First Name Middle Initial
Address_____
E-mail_____
City_____
State_____Zip_____
Sex ☐ M ☐ F Age_____
Birthdate_____
☐Married ☐ Widowed ☐ Single
☐Minor ☐ Separated ☐ Divorced
Patient Employer/School_____
Occupation_____
Employer/School Address_____
_____
Employer/School Phone (____)_____
Spouse's Name_____
Birthdate_____
SS#_____
Spouse's Employer_____
Whom may we thank for referring you?_____

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 _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative
_____
Please print name of Patient, Parent, Guardian or Personal Representative
_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (___) _____ Work (___) _____ Ext _____ Cell Phone(___) _____
Spouse's Work (___) _____ Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Home Phone (___) _____ Work Phone (___) _____

4 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	Burning sensation on tongue	☐Yes	☐No	Mouth pain, brushing	☐Yes	☐No
Bleeding gums	☐Yes	☐No	Chew on one side of mouth	☐Yes	☐No	Orthodontic treatment	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No	Cigarette, pipe, or cigar smoking	☐Yes	☐No	Pain around ear	☐Yes	☐No
			Clicking or popping jaw	☐Yes	☐No	Periodontal treatment	☐Yes	☐No
			Dry mouth	☐Yes	☐No	Sensitivity to cold	☐Yes	☐No
			Fingernail biting	☐Yes	☐No	Sensitivity to heat	☐Yes	☐No
			Food collection between teeth	☐Yes	☐No	Sensitivity to sweets	☐Yes	☐No
			Foreign objects	☐Yes	☐No	Sensitivity when biting	☐Yes	☐No
			Grinding Teeth	☐Yes	☐No	Sores or growths in your mouth	☐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			

How often do you floss?_____
How often do you brush?_____

5 HEALTH HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-Phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐Yes ☐No

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

AIDS/HIV	☐Yes	☐No	Epilepsy	☐Yes	☐No	Respiratory Disease	☐Yes	☐No
Anemia	☐Yes	☐No	Fainting or dizziness	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Arthritis, Rheumatism	☐Yes	☐No	Glaucoma	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Artificial Heart Valves	☐Yes	☐No	Headaches	☐Yes	☐No	Shortness of Breath	☐Yes	☐No
Artificial Joints	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Asthma	☐Yes	☐No	Heart Problems	☐Yes	☐No	Skin Rash	☐Yes	☐No
Back Problems	☐Yes	☐No	Hepatitis Type_____	☐Yes	☐No	Special Diet	☐Yes	☐No
Bleeding abnormally, with			Herpes	☐Yes	☐No	Stroke	☐Yes	☐No
Extractions or surgery	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Swollen Feet or Ankles	☐Yes	☐No
Blood Disease	☐Yes	☐No	Jaundice	☐Yes	☐No	Swollen Neck Glands	☐Yes	☐No
Cancer	☐Yes	☐No	Jaw Pain	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Liver Disease	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Circulatory Problems	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Tumor or growth on head		
Congenital Heart Lesions	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	or neck	☐Yes	☐No
Cortisone Treatments	☐Yes	☐No	Nervous Problems	☐Yes	☐No	Ulcer	☐Yes	☐No
Cough, persistent or bloody	☐Yes	☐No	Pacemaker	☐Yes	☐No	Venereal Disease	☐Yes	☐No
Diabetes	☐Yes	☐No	Psychiatric Care	☐Yes	☐No	Weight Loss, unexplained	☐Yes	☐No
Emphysema	☐Yes	☐No	Radiation Treatment	☐Yes	☐No			

Do you wear contact lenses? ☐Yes ☐No

Women

Are you pregnant? ☐Yes ☐No Due Date _____ Are you nursing? ☐Yes ☐No

Taking birth control pills? ☐Yes ☐No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (___) _____

ALLERGIES

☐Aspirin ☐Local Anesthetic

☐Barbiturates (Sleeping Pills) ☐Penicillin

☐Codeine ☐Sulfa

☐Iodine ☐Other _____

_____

☐Latex

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐Yes ☐No

For what conditions? _____

Are you taking any new medications? _____ If so what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐Yes ☐No

For what conditions? _____

Are you taking any new medications? _____ If so what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____