DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ____________________

SS/HIC/Patient ID # ____________________

Patient Name ____________________

____

E-mail ____________________

Address ____________________

City ____________________

State ____________________ Zip

Sex ☐ M ☐ F Age ____________________

Birthdate ____________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ Years

Patient Employer/School ____________________

Occupation ____________________

Employer/School Address ____________________

____

Employer/Schoole 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 ____________________ SS # ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

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ASSIGNMENT AND RELEASE

I certify that I, and/or myy dependent(s), 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 charger 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. The 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, Guarding or Personal Representative

____________________ ____________________
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) ____________________ Work (_____) ____________________ Ext _____ Cell (_____) ____________________

Spouse's Work (_____) ____________________ Best time and place to reach you ____________________

IN CASE OF EMERGENCY (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 any of the following:

- Bad Breath ☐ Yes ☐ No
- Blisters on lips or mouth ☐ Yes ☐ No
- Burning sensation on tongue ☐ Yes ☐ No
- Chew on one side of mouth ☐ Yes ☐ No
- Cigarette / cigar / pipe smoker ☐ Yes ☐ No
- Clicking or popping jaw ☐ Yes ☐ No
- Dry mouth ☐ Yes ☐ No
- Fingernail biting ☐ Yes ☐ No
- Food collection between 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 while brushing ☐ Yes ☐ No
- Orthodontic treatment ☐ Yes ☐ No
- Pain around the 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/growths in your mouth ☐ 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 included 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:

Condition		Condition		Condition	
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 extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ 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	Tonsilitis	☐ 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 or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, Persistant 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

☐ Barbituates (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? ☐ Yes ☐ No 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? ☐ Yes ☐ No If so, What? ______________________

Patient's Signature ______________________ Date ____________

Doctor's Signature ______________________ Date ____________