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 _____

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 #_____

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.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Cell _____

E-Mail _____ Best time to reach you _____

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

Name _____ Relationship_____

Home Phone _____ Work/Cell Phone _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State_____

Date of last dental visit _____

Date of last dental X-rays _____

Check "Yes" or "No" where indicated for all that apply:

Would you like whiter teeth?	❑ Yes	❑ No
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 filings	❑ 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 mouth	❑ Yes	❑ No

How often to you floss?_____

How often do you brush?_____

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5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

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

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

WOMEN: Are you: **Pregnant?** ❑ Yes, _____ Months ❑ No **Nursing?** ❑ Yes ❑ No **Taking birth control pills?** ❑ Yes ❑ No

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin ❑ Penicillin

❑ Barbiturates (Sleeping pills) ❑ Sulfa

❑ Codeine ❑ Other _____

❑ Iodine _____

❑ Latex _____

❑ Local Anesthetic _____

X _____

SIGNATURE OF PATIENT OR PARENT OF MINOR

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 _____

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