NEW PATIENT REGISTRATION / HEALTH HISTORY

Date __/__/__ SS# _____

Patient Name _____
Last First Middle

Address _____
City State Zip

Email _____ Drivers License # _____

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

Sex ☐M ☐F Birthdate __/__/__ Age: _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Occupation _____ Employer/School _____ Employer/School Phone( ) _____

Spouse's Name _____ Birthdate __/__/__ Spouse's Employer _____

Spouse's Cell( ) _____ Spouse's Work( ) _____ Ext _____

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

Name _____ Relationship _____

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

Whom may we thank for the referral? _____

GENERAL INFORMATION

PRIMARY INSURANCE

Subscriber's Name _____ *Birthdate* __/__/__ *SS#* _____

Relationship to Patient _____ *Employer* _____

Employer Phone( ) _____ *Employer Address* _____

Insurance Co. _____ *Insurance Co. Phone #(*) _____

Insurance Co. Address _____

Group # _____ *ID #* _____

SECONDARY INSURANCE

Subscriber's Name _____ *Birthdate* __/__/__ *SS#* _____

Relationship to Patient _____ *Employer* _____

Employer Phone( ) _____ *Employer Address* _____

Insurance Co. _____ *Insurance Co. Phone #(*) _____

Insurance Co. Address _____

Group # _____ *ID #* _____

Assignment and Release

I certify that I, and/or my 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 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 or Companies 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

DENTAL INSURANCE

Reason for today's visit_____

Former Dentist_____ City/State_____

Date of last dental visit_____ Date of last dental x-rays_____

Please mark "Yes" or "No" if you have any of the following:

Bad Breath	☐Yes	☐No	Pain around ear	☐Yes	☐No
Bleeding Gums	☐Yes	☐No	Periodontal treatment	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No	Sensitivity to cold	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No	Sensitivity to heat	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No	Sensitivity to sweets	☐Yes	☐No
Cigarette, pipe or cigar smoking	☐Yes	☐No	Sensitivity when biting	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No	Sores or growths in your mouth	☐Yes	☐No
Dry Mouth	☐Yes	☐No	Teeth previously extracted	☐Yes	☐No
Food collection between teeth	☐Yes	☐No			
Grinding teeth	☐Yes	☐No			
Gums swollen or tender	☐Yes	☐No			
Jaw pain	☐Yes	☐No			
Lip or cheek biting	☐Yes	☐No			
Loose teeth or broken fillings	☐Yes	☐No			
Mouth breathing	☐Yes	☐No			
Orthodontic treatment	☐Yes	☐No			

How often do you floss?_____

How often do you brush?_____

Is there anything about the appearance of your teeth that you would like to change?_____

DENTAL HISTORY

Are you under a physicians care right now? ☐Yes ☐No *If yes, please explain*_____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No *If yes, please explain*_____

Have you ever had a serious head or neck injury? ☐Yes ☐No *If yes, please explain*_____

Please list any medications, vitamins, or supplements you are currently taking_____

Are you on a special diet? ☐Yes ☐No *If yes, please explain*_____

Do you use tobacco? ☐Yes ☐No If yes, would you like to quit? ☐Yes ☐No Do you use controlled substances? ☐Yes ☐No

Please mark "Yes" or "No" if you have or have had any of the following:

Acid reflux	☐Yes	☐No	Chemical dependency	☐Yes	☐No	Hypoglycemia	☐Yes	☐No
AIDS/HIV	☐Yes	☐No	Chemotherapy	☐Yes	☐No	Irregular heartbeat	☐Yes	☐No
Anemia	☐Yes	☐No	Circulatory problems	☐Yes	☐No	Kidney problems	☐Yes	☐No
Angina	☐Yes	☐No	Cold sores/fever blisters	☐Yes	☐No	Liver problems	☐Yes	☐No
Arthritis/Gout/ Rheumatism	☐Yes	☐No	Diabetes	☐Yes	☐No	Low blood pressure	☐Yes	☐No
Artificial heart valves	☐Yes	☐No	Epilepsy/Seizures	☐Yes	☐No	Lung disease	☐Yes	☐No
Artificial joints	☐Yes	☐No	Glaucoma	☐Yes	☐No	Psychiatric care	☐Yes	☐No
Asthma	☐Yes	☐No	Hay fever	☐Yes	☐No	Radiation treatments	☐Yes	☐No
Back problems	☐Yes	☐No	Headaches	☐Yes	☐No	Stomach/ Intestinal disease	☐Yes	☐No
Bleeding abnormally with extractions or surgery	☐Yes	☐No	Heart trouble/Disease	☐Yes	☐No	Stroke	☐Yes	☐No
Bruise easily	☐Yes	☐No	Hepatitis A, B, or C	☐Yes	☐No	Thyroid problems	☐Yes	☐No
Cancer	☐Yes	☐No	Herpes	☐Yes	☐No	Tonsillitis	☐Yes	☐No
			High blood pressure	☐Yes	☐No			
			High cholesterol	☐Yes	☐No			

Any other diseases or conditions not listed above?_____

Please check *ALL* allergies, no matter how severe: ☐Aspirin ☐Barbiturates (Sleeping Pills) ☐Codeine ☐Iodine ☐Latex ☐Local anesthetic ☐Penicillin ☐Sulfa ☐Other_____

Women: Are you pregnant/trying to get pregnant? ☐Yes ☐No *If yes, due date:*_____

Taking oral contraceptives? ☐Yes ☐No Nursing: ☐Yes ☐No

MEDICAL HISTORY

Patient Signature Date_