



DENTAL REGISTRATION AND HISTORY

Date \_\_\_/\_\_\_/\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

PATIENT INFORMATION

Name \_\_\_\_\_ SS/HIC/Patient ID # \_\_\_\_\_  
 Last Name First Name MI  
 Address \_\_\_\_\_ Email \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 M  F Age \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_  Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years  
 Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer/School Address \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_  
 Who referred you to our office? \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

PRIMARY INSURANCE


Person Responsible for Account \_\_\_\_\_  
 Last Name First Name Middle Initial  
 Relation to Patient \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ SSN \_\_\_ - \_\_\_ - \_\_\_\_\_  
 Address (if different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Person Responsible Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
 Names of other dependents on plan \_\_\_\_\_

ADDITIONAL INSURANCE

Is the patient covered by additional insurance?  Y  N  
 Subscriber Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ Relation \_\_\_\_\_  
 Address (if different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Subscriber Employed By \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ SSN \_\_\_ - \_\_\_ - \_\_\_\_\_  
 Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
 Names of other dependents on plan \_\_\_\_\_



ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with:

\_\_\_\_\_ Insurance Company(ies)

and assign directly to Dr. \_\_\_\_\_ all insurance benefits, in any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

The above-mentioned doctor 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 Date

\_\_\_\_\_/\_\_\_\_\_ Printed name of Patient, Parent, Guardian or Personal Representative Relationship to patient

DENTAL HISTORY

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for today's visit \_\_\_\_\_ Date of last dental care \_\_\_/\_\_\_/\_\_\_\_\_  
Former dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_/\_\_\_/\_\_\_\_\_  
Address \_\_\_\_\_

Check ( ) if you have had problems with any of the following:

- Bad breath, Grinding teeth, Sensitivity to hot, Bleeding gums, Loose teeth or broken fillings, Sensitivity to sweets, Clicking or popping jaw, Periodontal treatment, Sensitivity when biting, Food collection between teeth, Sensitivity to cold, Sores or growths in the mouth

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_



MEDICAL 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).

Y  N

Have you had any serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N

If yes, give approximate date(s) \_\_\_\_\_

(Women)

Are you pregnant?  Y  N

Nursing?  Y  N

Taking birth control pills?  Y  N

Check ( ) if you have or have had any of the following:

- Anemia  Cortisone Treatments  Hepatitis  Scarlet Fever
 Arthritis, Rheumatism  Cough, Persistent  High Blood Pressure  Shortness of Breath
 Artificial Heart Valves  Cough Up Blood  HIV/AIDS  Skin Rash
 Artificial Joints  Diabetes  Jaw Pain  Stroke
 Asthma  Epilepsy  Kidney Disease  Swelling of Feet or Ankles
 Back Problems  Fainting  Liver Disease  Thyroid Problems
 Blood Disease  Glaucoma  Mitral Valve Prolapse  Tobacco Habit
 Cancer  Headaches  Pacemaker  Tonsillitis
 Chemical Dependency  Heart Murmur  Radiation Treatment  Tuberculosis
 Chemotherapy  Heart Problems  Respiratory Disease  Ulcer
 Circulatory Problems  Hemophilia  Rheumatic Fever  Venereal Disease

MEDICATIONS:

List any medications you are currently taking:

Pharmacy Name \_\_\_\_\_

Phone ( \_\_\_ ) \_\_\_\_\_

ALLERGIES:

- Aspirin  Sulfa
 Barbiturates (Sleeping Pills)  Latex \_\_\_\_\_
 Codeine  Other \_\_\_\_\_
 Local Anesthetic \_\_\_\_\_
 Penicillin \_\_\_\_\_

SIGNATURE:

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date \_\_\_/\_\_\_/\_\_\_\_\_ Signature \_\_\_\_\_