

REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____
SS#/Patient ID # _____
Patient Name _____

Address _____
City _____ State _____ Zip _____
How long? _____ Rent Own
E-mail _____
Sex M F Age _____
Birth date _____
Driver's License # _____
 Married Widowed Single Minor
 Separated Divorced Partnered for ___ years
Occupation _____
Patient Employer/School _____
How long at this Employer/School _____
Employer/School Address _____
Employer/School Phone _____
Spouse's Name _____
Spouse's Birthdate _____
Spouse's SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is financially responsible for this account?

Relationship to patient _____
Insurance Co. _____

Group# _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birth date _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Insurance Assignment
I certify that I, and/or my dependents(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.
Financial and Personal Health Information
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 for treatment, payment and health care operations. 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 CREDIT REFERENCES

Name of bank _____ Branch _____
Bank Cards (VISA/MC) _____ Gas Cards _____
_____ Store Account or other _____

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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
- 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 fillings 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
- Sore or growths in your mouth Yes No
- How often do you floss? _____
- How often do you brush? _____

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HEALTH HISTORY

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

- | | | |
|---|--|--|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin rash <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Special diet <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen feet or ankles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen neck glands <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital heart lesions <input type="checkbox"/> Yes <input type="checkbox"/> No | Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone treatments <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent/bloody <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight loss (unexplained) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric care <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Radiation treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | |

MEDICATIONS

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

Pharmacy Name _____
 Phone (____) _____

ALLERGIES

- Aspirin
- Barbiturates (Sleeping pills)
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other _____