DENTAL REGISTRATION AND HISTORY

Section 1: PATIENT INFORMATION

Date: _____

SS/HIC/Patient ID #: _____

Patient Name: _____
Last Name

_____ _____
First Name Middle Initial

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Sex: ☐ M ☐ F **Birthdate:** _____ **Age:** _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School: _____

Occupation: _____

Employer/School Address: _____

_____

Employer/School Phone: _____

SPOUSE INFORMATION

Spouse's Name: _____

Birthdate: _____

SSN: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

_____

Section 2: DENTAL INSURANCE

Who is responsible for the account? _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name: _____

Birthdate: _____ **SSN:** _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(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. I understand that I am financially responsible for a I charges whether or not paid by insurance. I authorize the use of my signature on at 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. 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

Section 3: PHONE NUMBERS

Home Phone: _____ **Work Phone:** _____ **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.)

Contact Name: _____ **Relationship:** _____

Home Phone: _____ **Work Phone:** _____ **Ext:** _____ **Cell Phone:** _____

Section 4: DENTAL HISTORY

Reason for today's visit: _____

_____

Former Dentist: _____

City/State: _____

Date of last dental visit: _____

Date of last dental X-rays: _____

Select "Y"(Yes) or "N" (No) to indicate if you have, or have had any of the following:

Bad breath	☐ Y	☐ N	Burning sensation on tongue	☐ Y	☐ N	Mouth breathing	☐ Y	☐ N
Bleeding gums	☐ Y	☐ N	Chew on one side of mouth	☐ Y	☐ N	Mouth pain, brushing	☐ Y	☐ N
Blisters on lips or mouth	☐ Y	☐ N	Cigarette, pipe, or cigar smoking	☐ Y	☐ N	Orthodontic treatment	☐ Y	☐ N
			Clicking or popping jaw	☐ Y	☐ N	Pain around ear	☐ Y	☐ N
			Dry mouth	☐ Y	☐ N	Periodontal treatment	☐ Y	☐ N
			Fingernail biting	☐ Y	☐ N	Sensitivity to cold	☐ Y	☐ N
			Food collection between teeth	☐ Y	☐ N	Sensitivity to heat	☐ Y	☐ N
			Foreign objects	☐ Y	☐ N	Sensitivity to sweets	☐ Y	☐ N
			Grinding teeth	☐ Y	☐ N	Sensitivity when biting	☐ Y	☐ N
			Gums swollen or tender	☐ Y	☐ N	Sores or growths in your mouth	☐ Y	☐ N
			Jaw pain or tiredness	☐ Y	☐ N			
			Lip or cheek biting	☐ Y	☐ N	How often do you floss?		
			Loose teeth or broken filings	☐ Y	☐ N	How often do you brush?		

Section 5: DENTAL 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). ☐ Yes ☐ No

Select "Y"(Yes) or "N" (No) to indicate if you have, or have had any of the following:

AIDS/HIV	☐ Y	☐ N	Epilepsy	☐ Y	☐ N	Respiratory Disease	☐ Y	☐ N
Anemia	☐ Y	☐ N	Fainting or dizziness	☐ Y	☐ N	Rheumatic Fever	☐ Y	☐ N
Arthritis, Rheumatism	☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Scarlet Fever	☐ Y	☐ N
Artificial Heart Valves	☐ Y	☐ N	Headaches	☐ Y	☐ N	Shortness of Breath	☐ Y	☐ N
Artificial Joints	☐ Y	☐ N	Heart Murmur	☐ Y	☐ N	Sinus Trouble	☐ Y	☐ N
Asthma	☐ Y	☐ N	Heart Problems	☐ Y	☐ N	Skin Rash	☐ Y	☐ N
Back Problems	☐ Y	☐ N	Hepatitis Type:	☐ Y	☐ N	Special Diet	☐ Y	☐ N
Bleeding abnormally, with extractions or surgery	☐ Y	☐ N	Herpes	☐ Y	☐ N	Stroke	☐ Y	☐ N
			High Blood Pressure	☐ Y	☐ N	Swollen Feet or Ankles	☐ Y	☐ N
Blood Disease	☐ Y	☐ N	Jaundice	☐ Y	☐ N	Swollen Neck Glands	☐ Y	☐ N
Cancer	☐ Y	☐ N	Jaw Pain	☐ Y	☐ N	Thyroid problems	☐ Y	☐ N
Chemical Dependency	☐ Y	☐ N	Kidney Disease	☐ Y	☐ N	Tonsillitis	☐ Y	☐ N
Chemotherapy	☐ Y	☐ N	Liver Disease	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Circulatory Problems	☐ Y	☐ N	Low Blood Pressure	☐ Y	☐ N	Tumor or growth on head or neck	☐ Y	☐ N
Congenital Heart Lesions	☐ Y	☐ N	Mitral Valve Prolapse	☐ Y	☐ N			
Cortisone Treatments	☐ Y	☐ N	Nervous Problems	☐ Y	☐ N	Ulcer	☐ Y	☐ N
Cough, persistent or bloody	☐ Y	☐ N	Pacemaker	☐ Y	☐ N	Venereal Disease	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Psychiatric Care	☐ Y	☐ N	Weight Loss, unexplained	☐ Y	☐ N
Emphysema	☐ Y	☐ N	Radiation Treatment	☐ Y	☐ N			

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

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

Section 6: UPDATES (To be filled in at future appointment)

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:** _____

Submit via Email