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. _____

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 _____ Ext. _____ 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 MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin
❑ Barbiturates (Sleeping Pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other _____

_____

Reason for Today's Visit:

_____

_____

5 HEALTH HISTORY

Physician's Name _____ Date of Last Visit _____

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

AIDS	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Fainting or dizziness	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No
Bleeding Abnormally with			Type _____			Skin Rash	❑ Yes	❑ No
Extractions or Surgery	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	HIV Positive	❑ Yes	❑ No	Swelling of Feet		
Chemical Dependency	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	or Ankles	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Jaw Pain	❑ Yes	❑ No	Swollen Neck Glands	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Cortisone Treatments	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Cough, Persistent or			Mitral Valve Prolapse	❑ Yes	❑ No	Tumor or Growth		
Bloody	❑ Yes	❑ No	Nervous Problems	❑ Yes	❑ No	on Head or Neck	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Ulcer	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Women: Are you pregnant?	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Do you wear contact lenses?	❑ Yes	❑ No	Are you nursing?	❑ Yes	❑ No	Unexplained Weight Loss	❑ Yes	❑ No
			Due Date _____					

6 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	Burning Sensation on Tongue	❑ Yes	❑ No	Loose Teeth or Broken Fillings	❑ Yes	❑ No
Bleeding Gums	❑ Yes	❑ No	Chew on One Side of Mouth	❑ Yes	❑ No	Mouth Breathing	❑ Yes	❑ No
Blisters on lips/mouth	❑ Yes	❑ No	Cigarette, pipe, or Cigar Smoking	❑ Yes	❑ No	Mouth Pain, Brushing	❑ Yes	❑ No
			Clicking or Popping Jaw	❑ Yes	❑ No	Orthodontic Treatment	❑ Yes	❑ No
			Dry Mouth	❑ Yes	❑ No	Pain Around Ear	❑ Yes	❑ No
			Fingernail Biting	❑ Yes	❑ No	Periodontal Treatment	❑ Yes	❑ No
			Food Collection Between the Teeth	❑ Yes	❑ No	Sensitivity to Cold	❑ Yes	❑ No
			Foreign Objects	❑ Yes	❑ No	Sensitivity to Heat	❑ Yes	❑ No
			Grinding Teeth	❑ Yes	❑ No	Sensitivity to Sweets	❑ Yes	❑ No
			Gums Swollen or Tender	❑ Yes	❑ No	Sensitivity when Biting	❑ Yes	❑ No
			Jaw Pain or Tiredness	❑ Yes	❑ No	Sores/Growths in Mouth	❑ Yes	❑ No
			Lip or Cheek Biting	❑ Yes	❑ No	How often do you floss? _____		
						How often do you brush? _____		

7 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? _____

Parent's Signature _____ Date _____

Doctor's Signature _____ Date _____