DENTAL REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date ______________________

SS/HIC/Patient ID# ______________________

Patient Name ______________________
Last Name

____
First Name Middle Initial

Address ______________________

E-mail ______________________

City ______________________

State ______________ Zip ______________

Sex ◯ M ◯ F Age ______________

Birthdate ______________________

◯ Married ◯ Widowed ◯ Single ◯ Minor

◯ Separated ◯ Divorced ◯ Partnered for ◯ Years

Patient Employer/School ______________________

Occupation ______________________

Employer/School Address ______________________

____

Employer/School Phone ______________________

Spouse's Name ______________________

Birthdate ______________________

SS# ______________________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

2. DENTAL INSURANCE

Who is the 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. ______________________

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 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(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 data 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. 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 filling	◯ 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
Stores or growths in your mouth	◯ Yes	◯ No
How often do you floss?	◯ Yes	◯ No
How often do you brush?	◯ Yes	◯ No

5. HEALTH 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

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

Condition	Yes	No
AIDS/HIV	◯ Yes	◯ No
Anemia	◯ Yes	◯ No
Arithritis, Rheumatism	◯ Yes	◯ No
Artificial Heart Valves	◯ Yes	◯ No
Artificial Joints	◯ Yes	◯ No
Asthma	◯ Yes	◯ No
Back Problems	◯ Yes	◯ No
Bleeding abnormally, with extractions or surgery	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No
Cancer	◯ Yes	◯ No
Chemical Dependency	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No
Circulatory Problems	◯ Yes	◯ No
Congenital Heart Lesions	◯ Yes	◯ No
Cortisone Treatments	◯ Yes	◯ No
Cough, persistent or bloody	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No

Condition	Yes	No
Epilepsy	◯ Yes	◯ No
Fainting or dizziness	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No
Headaches	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No
Heart Problems	◯ Yes	◯ No
Hepatitis Type	◯ Yes	◯ No
Herpes	◯ Yes	◯ No
High Blood Pressure	◯ Yes	◯ No
Jaundice	◯ Yes	◯ No
Jaw Pain	◯ Yes	◯ No
Kidney Disease	◯ Yes	◯ No
Liver Disease	◯ Yes	◯ No
Low Blood Pressure	◯ Yes	◯ No
Mitral Valve Prolapse	◯ Yes	◯ No
Nervous Problems	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No
Psychiatric Care	◯ Yes	◯ No
Radiation Treatment	◯ Yes	◯ No

Condition	Yes	No
Respiratory Disease	◯ Yes	◯ No
Rheumatic Fever	◯ Yes	◯ No
Scarlet Fever	◯ Yes	◯ No
Shotness of Birth	◯ Yes	◯ No
Sinus Trouble	◯ Yes	◯ No
Skin Rash	◯ Yes	◯ No
Special Diet	◯ Yes	◯ No
Stroke	◯ Yes	◯ No
Swollen Feet or Ankles	◯ Yes	◯ No
Swollen Neck Glands	◯ Yes	◯ No
Thyroid Problems	◯ Yes	◯ No
Tonsillitis	◯ Yes	◯ No
Tuberculosis	◯ Yes	◯ No
Tumor or growth on head or neck	◯ Yes	◯ No
Ulcer	◯ Yes	◯ No
Venereal Disease	◯ Yes	◯ No
Weight Loss, Unexplained	◯ Yes	◯ No

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
- ☐ Latex
- ☐ Barbiturates (Sleeping pills)
- ☐ Local Anesthetic
- ☐ Codeine
- ☐ Penicillin
- ☐ Iodine
- ☐ Sulfa

Other ____________________

____

6. 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? ____________

Patient's Signature ____________________ Date ____________

Doctor's Signature ____________________ Date ____________

Has there been ay change in your health since your last dental appointment? ○ Yes ○ No

For what conditions? ____________________

Are you taking any new medications? ____________ If so, What? ____________

Patient's Signature ____________________ Date ____________

Doctor's Signature ____________________ Date ____________