DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID #_____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

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 _____

Birthday _____

SS# _____

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. _____

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 benefit, if any, otherwise payable to me for service 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 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 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	Mouth breathing	___ Yes	___ No
Bleeding gums	___ Yes	___ No	Chew on one side of mouth	___ Yes	___ No	Mouth pain, brushing	___ Yes	___ No
Blisters on lips or mouth	___ Yes	___ No	Cigarette, pipe, or cigar smoking	___ Yes	___ No	Orthodontic treatment	___ Yes	___ No
			Clicking or popping jaw	___ Yes	___ No	Pain around ear	___ Yes	___ No
			Dry mouth	___ Yes	___ No	Periodontal treatment	___ Yes	___ No
			Fingernail biting	___ Yes	___ No	Sensitivity to cold	___ Yes	___ No
			Food collection between the teeth	___ Yes	___ No	Sensitivity to heat	___ Yes	___ No
			Foreign objects	___ Yes	___ No	Sensitivity to sweets	___ Yes	___ No
			Grinding teeth	___ Yes	___ No	Sensitivity when biting	___ Yes	___ No
			Gums swollen or tender	___ Yes	___ No	Sores or growths in your mouth	___ Yes	___ No
			Jaw pain or tiredness	___ Yes	___ No	How often do you floss? _____		
			Lip or cheek biting	___ Yes	___ No			
			Loose teeth or broken fillings	___ Yes	___ No	How often do you brush? _____		

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DENTAL REGISTRATION AND HISTORY

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 lonimin, 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:

AIDS/HIV	___ Yes ___ No	Epliepsy	___ Yes ___ No	Respiratory Disease	___ Yes ___ No
Anemia	___ Yes ___ No	Fainting or dizziness	___ Yes ___ No	Rheumatic Fever	___ Yes ___ No
Arthritis, Rheumatism	___ Yes ___ No	Glaucoma	___ Yes ___ No	Scarlet Fever	___ Yes ___ No
Artificial Heart Valves	___ Yes ___ No	Headaches	___ Yes ___ No	Shortness of Breath	___ Yes ___ No
Artificial Joints	___ Yes ___ No	Heart Murmur	___ Yes ___ No	Sinus Trouble	___ Yes ___ No
Asthma	___ Yes ___ No	Heart Problems	___ Yes ___ No	Skin Rash	___ Yes ___ No
Back Problems	___ Yes ___ No	Hepatitis Type _____	___ Yes ___ No	Special Diet	___ Yes ___ No
Bleeding abnormally, with Extractions or surgery	___ Yes ___ No	Herpes	___ Yes ___ No	Stroke	___ Yes ___ No
		High Blood Pressure	___ Yes ___ No	Swollen Feet or Ankles	___ Yes ___ No
Blood Disease	___ Yes ___ No	Jaundice	___ Yes ___ No	Swollen Neck Glands	___ Yes ___ No
Cancer	___ Yes ___ No	Jaw Pain	___ Yes ___ No	Thyroid Problems	___ Yes ___ No
Chemical Dependency	___ Yes ___ No	Kidney Disease	___ Yes ___ No	Tonsillitis	___ Yes ___ No
Chemotherapy	___ Yes ___ No	Liver Disease	___ Yes ___ No	Tuberculosis	___ Yes ___ No
Circulatory Problems	___ Yes ___ No	Low Blood Pressure	___ Yes ___ No	Tumor or growth on head or neck	___ Yes ___ No
Congenital Heart Lesions	___ Yes ___ No	Mitral Valve Prolapse	___ Yes ___ No		
Cortisone Treatments	___ Yes ___ No	Nervous Problems	___ Yes ___ No	Ulcer	___ Yes ___ No
Cough, persistent bloody	___ Yes ___ No	Pacemaker	___ Yes ___ No	Venereal Disease	___ Yes ___ No
Diabetes	___ Yes ___ No	Psychiatric Care	___ Yes ___ No	Weight Loss, unexplained	___ Yes ___ No
Emphysema	___ Yes ___ No	Radiation Treatment	___ Yes ___ No	Weight Loss, explained	___ 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 (____) _____

ALLEGRIES

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

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

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