DENTAL REGISTRATION AND HISTORY

PLEASE PRINT • ANSWER ALL QUESTIONS

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? _____

DENTAL INFORMATION

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 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 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

PHONE NUMBERS

Phone (_____)_____ Work (_____)_____ Ext _____ Cell (_____)_____

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 (_____) _____

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate. The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing or processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE. In the event of default of payment your account will be turned over to a collection agency. I agree to pay all reasonable court costs, attorney fees and collection fees up to 50% of the delinquent balance.

Date _____ Signature _____

PATIENT, PARENT OR AGENT (MUST BE 18 YEARS OR OLDER)

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelviz, Didronel, Boniva. ❑ Yes ❑ No

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

❑ Asprin ❑ Local Anesthetic

❑ Barbiturates (Sleeping Pills) ❑ Penicillin

❑ Codeine ❑ Sulfa

❑ Iodine ❑ Other _____

❑ Latex _____

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	Chew on one side of mouth	❑ Yes ❑ No	Mouth breathing	❑ Yes ❑ No
Bleeding gums	❑ Yes ❑ No	Cigarette, pipe, or cigar smoking	❑ Yes ❑ No	Mouth pain, brushing	❑ Yes ❑ No
Blisters on lips or mouth	❑ Yes ❑ No	Clicking or popping jaw	❑ Yes ❑ No	Orthodontic treatment	❑ Yes ❑ No
Burning sensation on tongue	❑ 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 tenderness	❑ Yes ❑ No	Sores or growths in your mouth	❑ Yes ❑ No
		Lip or cheek biting	❑ Yes ❑ No	How often do you floss? _____	
		Loose teeth or broken fillings	❑ Yes ❑ No	How often do you brush? _____	

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____