DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date__ __/__ __/__ __ __ __ SS # __ __ __-__ __-__ __ __ __
Patient Name _____
Address _____
_____
City State Zip
E-mail _____
Cell Phone # (__ __ __) __ __ __-__ __ __ __
Work Phone # (__ __ __) __ __ __-__ __ __ __ EXT ____
Home Phone # (__ __ __) __ __ __-__ __ __ __
Best time & place to reach you _____-_____
Best Time For Appointments:_____Days_____
Sex: ☐ M ☐ F Birthdate____/____/_____Age____
☐Single ☐Married ☐Widowed ☐Divorced ☐Separated
Driver's License # _____
Occupation _____
Employer _____
Employer Address _____
_____Years at Job____
Spouse Name _____
Birthdate____/____/_____SS#__ __ __-__ __-__ __ __ __
Occupation _____
Spouse's Employer _____
Work Phone#_____/_____/_____Years at Job____
IN CASE OF EMERGENCY CONTACT (Not living with you)
NAME_____RELATION_____
Cell Phone # (__ __ __) __ __ __-__ __ __ __
Home Phone # (__ __ __) __ __ __-__ __ __ __
WHOM MAY WE THANK FOR REFERRING YOU_____

2 DENTAL INSURANCE

Who is financially responsible for this account?____
_____
___
Relationship to patient _____
Insurance Co. _____
Group#_____
Is Patient covered by additional insurance ☐Yes ☐No
Additional Insurance Co. _____
Subscriber's Name_____
Birthdate____/____/_____SS # __ __ __-__ __-__ __ __ __
Relationship to patient _____
Insurance Co. _____
Group #_____
Dependents Names covered under this plan:
1. _____
2. _____
3. _____

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.

X_____
Responsible party signature
_____
_____
Relationship Date

3 DENTAL HISTORY

Reason for today's visit_____ Date of last X-rays taken__ __/__ __/__ __ __ __
Former Dentist_____ Date of last dental visit__ __/__ __/__ __ __ __
Why did you leave your last dental office? _____
What are your expectations and concerns regarding your dental treatment? _____
_____
Are you satisfied with the appearance of your teeth? If not, what would you like to change_____
_____
Would you like your teeth to be whiter? _____
What can we do to make your dental visits meet your expectations? _____
_____

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

Bad Breath	☐Yes	☐No	Food collection between the teeth	☐Yes	☐No	Pain around ear	☐Yes	☐No
Bleeding gums	☐Yes	☐No				Periodontal treatment	☐Yes	☐No
Blisters on lips/mouth	☐Yes	☐No	Foreign objects	☐Yes	☐No	Sensitivity to cold	☐Yes	☐No
Burning sensation on Tongue	☐Yes	☐No	Grinding teeth	☐Yes	☐No	Sensitivity to hot	☐Yes	☐No
Chew on one side of Mouth	☐Yes	☐No	Gums swollen or tender	☐Yes	☐No	Sores or growths in mouth	☐Yes	☐No
Cigarette, pipe or cigar smoking	☐Yes	☐No	Jaw pain/tiredness	☐Yes	☐No	Do you floss?	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No	Lip/cheek biting	☐Yes	☐No	How often? _____		
Dry mouth	☐Yes	☐No	Loose teeth/broken fillings	☐Yes	☐No	Do you brush?	☐Yes	☐No
Fingernail biting	☐Yes	☐No	Mouth breathing	☐Yes	☐No	How often? _____		
			Mouth pain/brushing	☐Yes	☐No	Do you rinse?	☐Yes	☐No
			Orthodontic treatment	☐Yes	☐No	How often? _____		
						What Type & Brand of Tooth paste do you use?_____		

4 HEALTH HISTORY

Physicians 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 Phenteramine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine). ☐Yes ☐No

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

AIDS/HIV	☐Yes	☐No	Do you wear Contact Lense?	☐Yes	☐No	Psychiatric care	☐Yes	☐No
Anemia	☐Yes	☐No	Emphysema	☐Yes	☐No	Radiation treatment	☐Yes	☐No
Arthritis/Rheumatism	☐Yes	☐No	Fainting/Dizziness	☐Yes	☐No	Respiratory disease	☐Yes	☐No
Artificial Heart Valves	☐Yes	☐No	Glaucoma	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Artificial Joints	☐Yes	☐No	Headaches	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Asthma	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Shortness of Breath	☐Yes	☐No
Back Problems	☐Yes	☐No	Heart Problems	☐Yes	☐No	Sinus trouble	☐Yes	☐No
Bleeding abnormally with Extractions/Surgery	☐Yes	☐No	Hepatitis type_____	☐Yes	☐No	Skin rash	☐Yes	☐No
Blood disease	☐Yes	☐No	Herpes	☐Yes	☐No	Special Diet	☐Yes	☐No
Cancer	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Stroke	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	Jaundice	☐Yes	☐No	Swelling of Feet 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 bloody	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	Tumor or growth on Head and Neck	☐Yes	☐No
Diabetes	☐Yes	☐No	Nervous Problems	☐Yes	☐No	Ulcer	☐Yes	☐No
Women ONLY:			Pacemaker/Implants	☐Yes	☐No	Venereal diseases	☐Yes	☐No
Are you Pregnant?	☐Yes	☐No	Any Surgery/Implants	☐Yes	☐No	Weight Loss, unexplained	☐Yes	☐No
			Delivery due date__/__/____			Are you Nursing?	☐Yes	☐No

5 MEDICATIONS

Are you under the care of a Physician? ☐Yes ☐No
If yes, then for What Conditions?_____

Are you taking any Medications at this time? ☐Yes ☐No
List Medications you are currently taking:

Have you ever had a Serious Injury to your mouth? ☐Yes ☐No
If Yes, please explain _____

6 ALLERGIES

Do you have any Drug Allergies? ☐Yes ☐No
Which ones?_____

Have you ever had an adverse reaction to any medications? ☐Yes ☐No
If Yes, Which ones_____

Have you ever had an adverse reaction to any Medical or Dental treatment? ☐Yes ☐No
If Yes, please explain _____

7 ACKNOWLEDGEMENT

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any error or omissions that I have made in the completion of this form. I have received a copy of this office's Notice of Privacy practices. I authorize your office to contact me by third party promotions and notifications by email. I am financially responsible for all the treatment provided.

_____ X_____ __/__/____

PLEASE PRINT NAME SIGNATURE DATE

FOR MINOR PATIENTS ONLY ☐_____ X_____ __/__/____

SIGNATURE OF PARENT / LEGAL GUARDIAN DATE