DENTAL REGISTRATION AND HISTORY

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PATIEN	IT IN	FOR	MATION		D	ENTAL INSURAN	C E	
Date//Patient Name	SS#			Who is	financi	ally responsible for this acco	ount?	
Address				_		CALL TO		
						patient		
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Celi Phone # (_)			Addition	nt cover	ance Co	62 1140	
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☐Single ☐Married ☐	Widowed	LIDIVO	ced LiSeparated	Depend	dents Na	mes covered under this plan:		
Driver's License #							*	
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Spouse Name	SS	S#		Dr.		and assign directly to all insurance be	enefits, if any,	
				otherwise	e pavable	to me for services rendered. I understa	ind that I am	
Spouse's Employer				financially hereby a	y responsi uthorize th	ble for all charges whether or not paid e doctor to release all information nece	essary to secure	e
Spouse's Employer/_ Work Phone#/_	/		_Years at Job	the paym	ent of ber	efits. I authorize the use of this signatu	ire on all insura	ance
IN CASE OF EMERGE	NCY CC	NTACT	(Not living with you)	submissi	ons.			
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Cell Phone # ()	· · ·		Respor	nsible part	y signature		
Home Phone # ()	_	1.0					
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Reason for today's vising Former Dentist Why did you leave you what are your expectar Are you satisfied with time Would you like your tea what can we do to make the work of t	r last der tions and the appearance the to be ke your or "No" '' or "No" '' yes '' yes '' Yes '' Yes	HII Intal official concer arance of whiter? Idental vis to indic No No	STORY e? ns regarding your dental f your teeth? If not, what sits meet your expectation ate if you have or had an Food collection between the teeth Foreign objects Grinding teeth Gums swollen or tender Jaw pain/tiredness Lip/cheek biting	treatme would y ns? yof the yes yes yes yes	Da D	g: Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to hot Sores or growths in mouth Do you floss? How often?	□Yes □Yes □Yes □Yes □Yes □Yes □	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □
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HEA	ALTI	н	STORY			11	
Physicians Name						Date of Last Visit/	
⊣ave vou ever taken	any of	the gr	oup of drugs collect	ively re	ferred	Date of Last Visit/ to as "Fen-phen"? These in	nclude
combinations of lon	imin, A	dipex,	Fastin (brand names	of Pher	nteram	ine), Pondimin (Fenfluram	ine) and
Redux (Dexfenfluram	nine). 🛚	lyes [□ No				
Place a mark on "Yes			ndicate if you have o	r had a	ny of t	he following:	
AIDS/HIV	□Yes		Do you wear Contact	П.,	П.,	Psychiatric care	□ _{Yes} □ _N □ _{Yes} □ _N
knem ia	□Yes		Lense?	□Yes		Radiation treatment	□Yes □N
arthritis/Rheumatism			Emphysema	□Yes		Respiratory disease Rheumatic Fever	□Yes □N
Artificial Heart Valves			Fainting/Dizziness			Scarlet Fever	□Yes □N
Artificial Joints	□Yes	10000000	Glaucom a Headaches			Shortness of Breath	□Yes □N
Asthma	□Yes		Head acries		□No	Sinustrouble	□Yes □N
Back Problems Bleeding abnormally w		LINO.	Heart Problems	□Yes		Skin rash	□Yes □N
extractions/Surgery	□Yes	□No	Hepatitistype	□Yes		Special Diet	□Yes □N
Blood disease	□Yes	30.00000	Herpes	□Yes		Stroke	□ _{Yes} □ _N
Cancer	□Yes		High Blood Pressure	70 mm 1997	□No	Swelling of Feet or Ankles	□Yes □N
Chemical Dependency			Jaundice	□Yes	\square_{No}	Swollen Neck Glands	□Yes □N
Chemotherapy	□Yes	\square_{No}	Jaw Pain	□Yes	\square_{No}	Thyroid problems	□ _{Yes} □ _N
Circulatory problems	□Yes	\square_{No}	Kidney disease		\square_{No}	Tonsillitis	□ _{Yes} □ _N
Congenital Heart			Liver disease	□Yes		Tuberculosis	□ _{Yes} □ _N
esions	□Yes		Low Blood Pressure	□Yes		Tumor or growth on Head	
Cortisone treatments	□Yes	\square_{No}	Mitral Valve Prolapse	□Yes		and Neck	□Yes □N
Cough, persistent or			Nervous Problems		□No	Ulcer	□Yes □N
oloody	□Yes		Pacemaker/Implants	□Yes		Venereal diseases	□Yes □N
Diabetes	⊔Yes	□йо	Any Surgery/Implants	⊔Yes	\square_{No}	Weight Loss, unexplained	□Yes □N
Women ONLY:	Пу	Пы.	Deline and dete	, ,		Are you Nursing?	□ _{Yes} □ _N
Are you Pregnant?	□ _{Yes}	□No	Delivery due date			Are you nursing?	-163 -14
4						7	
		. 1.7			12		
MED) I C A	TIO	N S		9	ALLERGIES	
Are you under the c If yes, then for What	are of t Condi	a Physi tions?_	cian? □ _{Yes} □ _{No}			ave any Drug Allergies? nes?	
Annual taking any M	Madiaa	tionogi	thic	-			
Are you taking any N time?	viedica	lionsa	□Yes □No	_		The state of the s	
List Medications you	are ci	rrently		Ha	ave vou	ever had an adverse	
List Medidations you						to any medications?	□Yes □No
			4	lf	Yes, Wh	nich ones	
1				_			
						ever had an adverse	
Have you ever had a	Seriou	ıs Injur	yto □Yes □No			to any Medical or Dental	
your mouth?					eat m er		□ _{Yes} □ _{No}
If Yes, please explain	١			11	Yes, ple	ease explain	
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member of his/her sta	in resp	offsible	Nation of Drivers	otioss 1	outhor	ira your office to contect m	e by third part
nave received a copy	orthis	office's	s Notice of Privacy pra	ctices. I	author	ize your office to contact m	ic by unit part
promotions and notifi	ications	by em		sponsibl	e for al	I the treatment provided.	,
			X	E A		DATE /	_/
PLEASE PRINT NAME			SIGNATUR	CE /		DATE	1
FOR MINOR PATIENTS ON	SLY LI_		XX	RE OF DA	RENT / I	EGAL GUARDIAN DATE	