## DENTAL REGISTRATION AND HISTORY

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PATIE	NT I	NFO	RMATION		D	ENTAL INSURAN	CE		
				_					
Date//	SS	#		Who is financially responsible for this account?					
Patient Name									
Address						and and			
						patient			
City		State		Insurai	nce Co ''				
E-mail					#				
Cell Phone # ( Work Phone # (	)			Is Patient covered by additional insurance □Yes □No					
Work Phone # (	<del>-</del>	EXT	Additional Insurance Co.						
Home Phone # (			Subscriber's Name						
Best time & place to re	ach you			Birthdate//SS #					
Best Time For Appoint Sex: ☐ M ☐ F Birthda	ments:		Days	Relationship to patient					
Sex: ☐ M ☐ F Birthda	ate	//	Age	Insurai	nce Co.				
☐Single ☐Married ☐									
Driver's License #						ames covered under this plan:			
Occupation				1					
Emanda var				2					
_ ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '				3		AND DELEASE			
. ,			Years at Job			AND RELEASE			
Spouse Name				I, the undersigned certify that I (or my dependent) have insurance coverage					
Birthdate//_	S	S#		with and assign directly to Dr all insurance benefits, if any,					
Occupation				otherwis	e payable	to me for services rendered. I understa	nd that I am		
Spouse's Employer					ible for all charges whether or not paid				
Work Phone# /	/		Years at Job	the navn	lutnorize t nent of he	he doctor to release all information nece nefits. I authorize the use of this signatu	essary to secure		
IN CASE OF EMERGE	NCY CO	ONTACT	(Not living with you)	submiss		nones. I demonze the doc of the signate			
NAME				Χ					
Cell Phone # (	)	-		Respo	nsible par	ty signature			
Home Phone # (	)								
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D E  Reason for today's visi Former Dentist	<b>N T A</b> l	L HI	STORY		Da		_/		
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Reason for today's visit Former Dentist Why did you leave you What are your expectated Are you satisfied with the Would you like your tea What can we do to make the What can we do to	NTAI  t r last deritions and he appeareth to be ke your or "No" □Yes □Yes □Yes □Yes □Yes	ntal officed concernance of whiter? dental virulation of the concernance of the concernace of the concernanc	STORY  See?  Ins regarding your dental of your teeth? If not, what sits meet your expectation between the teeth Foreign objects Grinding teeth Gums swollen or tender Jaw pain/tiredness Lip/cheek biting Loose teeth/broken	treatment would yours?	following Day on Divo	rate of last X-rays taken/ rate of last dental visit/_ ro change  g:  Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to hot Sores or growths in mouth Do you floss? How often? Do you brush? How often? Low often. Low o	□Yes □No		
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HEALTH HISTORY												
Physicians Name						Date of Last Visit /	1					
	any of	the a	roup of drugs collect	ivelv re	ferred	to as "Fen-phen"? These in						
						ine), Pondimin (Fenfluram						
Redux (Dexfenfluramine). DYes DNo												
Place a mark on "Ye	<b>s"</b> or "N	<b>lo</b> " to i	ndicate if you have o	r had a	ny of t	he following:						
AIDS/HIV	□Yes		Do you wear Contact	_		Psychiatric care	□ <sub>Yes</sub> □ <sub>No</sub>					
Anemia	□ <sub>Yes</sub>		Lense?	□ <sub>Yes</sub>		Radiation treatment	□ <sub>Yes</sub> □ <sub>No</sub>					
Arthritis/Rheumatism		□No	Em p h y sem a	□ <sub>Yes</sub>	□No	Respiratory disease	□ <sub>Yes</sub> □ <sub>No</sub>					
	□ <sub>Yes</sub>	□No	Fainting/Dizziness	□Yes	□No	Rheumatic Fever	□ <sub>Yes</sub> □ <sub>No</sub> □					
Artificial Joints	□ <sub>Yes</sub> □ <sub>Yes</sub>		Glaucoma	□ <sub>Yes</sub> □ <sub>Yes</sub>		Scarlet Fever	□ <sub>Yes</sub> □ <sub>No</sub>   □ <sub>Yes</sub> □ <sub>No</sub>					
Asthma Back Problems	□Yes	□ <sub>No</sub> □ <sub>No</sub>	Headaches Heart Murmur	□Yes	□ <sub>No</sub>	Shortness of Breath Sinus trouble	□Yes □No □Yes □No					
Bleeding abnormally w		□INO	Heart Problems	□Yes		Skin rash	□Yes □No					
Extractions/Surgery	□ <sub>Yes</sub>	$\square_{No}$	Hepatitis type	□Yes		Special Diet	□ <sub>Yes</sub> □ <sub>No</sub>					
Blood disease	□Yes		Herpes	□Yes	□No	Stroke	□Yes □No					
Cancer	□ <sub>Yes</sub>	$\square_{No}$	High Blood Pressure	□ <sub>Yes</sub>	$\square_{No}$	Swelling of Feet or Ankles	□ <sub>Yes</sub> □ <sub>No</sub>					
Chemical Dependency	□ <sub>Yes</sub>	$\square_{No}$	Jaundice	□ <sub>Yes</sub>	$\square_{No}$	Swollen Neck Glands	□ <sub>Yes</sub> □ <sub>No</sub>					
Chemotherapy	□ <sub>Yes</sub>	$\square_{No}$	Jaw Pain	□ <sub>Yes</sub>	$\square_{No}$	Thyroid problems	□ <sub>Yes</sub> □ <sub>No</sub>					
Circulatory problems	□ <sub>Yes</sub>	$\square_{No}$	Kidney disease	□ <sub>Yes</sub>	$\square_{No}$	Tonsillitis	□ <sub>Yes</sub> □ <sub>No</sub>					
Congenital Heart	_	_	Liver disease	□ <sub>Yes</sub>	□No	Tuberculosis	□ <sub>Yes</sub> □ <sub>No</sub>					
lesions	□Yes	□No	Low Blood Pressure	□Yes	□No	Tumor or growth on Head						
Cortisone treatments	⊔Yes	$\square_{No}$	Mitral Valve Prolapse	□Yes	□No	and Neck	□Yes □No □					
Cough, persistent or	□ <sub>Yes</sub>	Пы	Nervous Problems	□ <sub>Yes</sub> □ <sub>Yes</sub>	□ <sub>No</sub>	Ulcer	□ <sub>Yes</sub> □ <sub>No</sub> □					
bloody Diabetes	□ res □ Yes		Pacemaker/Implants Any Surgery/Implants			Venereal diseases	□Yes □No □Yes □No					
Women ONLY:	- res		Any Surgery/implants	- res	<u> </u>	Weight Loss, unexplained	Tes Divo					
Are you Pregnant?	□ <sub>Yes</sub>	□ <sub>No</sub>	Delivery due date		. — — —	_ Are you Nursing?	□ <sub>Yes</sub> □ <sub>No</sub>					
							_					
MED	O I C A	TIOI	N S		Ó	ALLERGIES						
Are you under the c If yes, then for What					you h	, , ,	□ <sub>Yes</sub> □ <sub>No</sub>					
Are you taking any M	Modicat	ioncat	thic				<del></del>					
Are you taking any Ntime?	viedicai	ionsai	□ <sub>Yes</sub> □ <sub>No</sub>				<del> </del>					
List Medications you	rare cu	rrently		Ha	ve vol	ı ever had an adverse						
List Wisdisdisons year	a a o o o		tuking.			to any medications?	□ <sub>Yes</sub> □ <sub>No</sub>					
						nich ones						
			<del> </del>				<del> </del>					
			<u>-</u>			ı ever had an adverse						
Have you ever had a	a Seriou	ıs Injury	y to $\square_{Yes} \square_{No}$			to any Medical or Dental						
your mouth?					eat m er		□ <sub>Yes</sub> □ <sub>No</sub>					
If Yes, please explain	)		<del></del>	IT.	res, pie	ease explain	<del></del>					
			<del> </del>									
A C K	NOV	VLEI	O G E M E N T									
				t of my	knowle	adge I will not hold my don	tist or any					
The above information	n is acc	curate a	nd complete to the bes	•		edge. I will not hold my den	=					
The above information member of his/her sta	on is acc	curate a	nd complete to the bes	ons that	I have	made in the completion of	this form. I					
The above information member of his/her state have received a copy	on is account responding this	curate and onsible office's	nd complete to the bes for any error or omissi Notice of Privacy pra	ons that ctices. I	I have author	made in the completion of ize your office to contact me	this form. I					
The above information member of his/her state have received a copy	on is account responding this	curate and onsible office's	nd complete to the bes for any error or omissi Notice of Privacy pra ail. I am financially res	ons that ctices. I	I have author	made in the completion of	this form. I					
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The above information member of his/her state have received a copy	on is according responsible of this of cations	curate and onsible office's	nd complete to the bes for any error or omissi Notice of Privacy pra ail. I am financially res	ons that ctices. I ponsible	I have author	made in the completion of ize your office to contact me	this form. I					