DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS # _____

Occupation _____

Spouse's Employer _____

Spouse's Employer Phone _____

Whom may we thank for referring you? _____

_____

And Phone Number _____

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, 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. If the account is turned over to an outside agency, I will be responsible for collection and attorney fees.

_____

Responsible Party Signature Date

3 NO DENTAL INSURANCE ASSIGNMENT AND RELEASE

Who is responsible for this account? _____ Relationship to Patient _____

Responsible party birth date _____ SS# _____

ASSIGNMENT AND RELEASE

I, the undersigned (or my dependent) am fully aware that I am responsible for all charges.

If the account is turned over to an outside agency, I will be responsible for collection and attorney fees.

_____ _____

Responsible Party Signature Date

4 PHONE NUMBERS

Home _____ Work _____ Ext. _____ Spouse's Work _____

Cell _____ E-Mail _____

Best time and number to reach you _____

IN CASE OF EMERGENCY, CONTACT *(Specify someone who does not live in your household.)*

Name _____ Relationship _____

Home Phone _____ Work Phone _____

-OVER-

5 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
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

6 HEALTH HISTORY

It is your responsibility to update us of any and all changes in your medical history.....i.e. Pregnancy, Heart Conditions, Diabetes, Medication changes, etc.

Physician's Name _____ Physician's Phone Number _____ Date of last visit _____

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

Acid Reflux	☐ Yes	☐ No
Anxiety / Stress Disorder	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Blood Disorder	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy / Radiation	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
C.O.P.D.	☐ Yes	☐ No
Colitis / IBS	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No
Down Syndrome	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Fever Blisters	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Issues	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Type _____		
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
HIV Positive / AIDS	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swelling of Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No
Women:		
Are you pregnant?	☐ Yes	☐ No
Due date _____		
Are you nursing	☐ Yes	☐ No

OTHER: _____

IF YES PLEASE EXPLAIN: _____

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Are you currently under pain management? ☐ Yes ☐ No

Pharmacy Name _____

Phone _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Food Allergies
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

_____

UPDATED

Patient Name

_____

_____

Date _____

Patient Name

_____

_____

Date _____