REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

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 certify that I, and/or my dependent(s), have insurance coverage wi

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefit
if any, otherwise payable to me for services rendered. I understand that I a
financially responsible for all charges whether or not paid by insurance, includir
any fees incurred in collecting any balance owed. I authorize the use of m
signature on all insurance submissions.

_____

The above-named dentist may use my health care information and may disclos
such information to the above-named Insurance Company(ies) and their agents f
the purpose of obtaining payment for services and determining insurance benefi
or the benefits payable for related services. This consent will end when my curre
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

3 PHONE NUMBERS

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

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 (_____) _____

– OVER –

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

_____

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? _____

5 MEDICAL HISTORY

Physician's Name _____ Address & Phone _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, c medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No _____

_____

_____

Do you take or have taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No _____

D0 you use tobacco? ☐ Yes ☐ No _____

Do you use controlled substances? ☐ Yes ☐ No _____

Women: Are you
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Hemphilia	☐ Yes	☐ No			
Alzheimer's Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ N
Anaphylaxis	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ N
Anemia	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ N
Angina	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ N
Arthritis/Gout	☐ Yes	☐ No	Epilepsy os Seizures	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Shingles	☐ Yes	☐ N
Artificial Heart Valve	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ N
Artificial Joint	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ N
Asthma	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ N
Blood Disease	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ N
Blood Transfusion	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ N
Breathing Problems	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ N
Bruise Easily	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ N
Cancer	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ N
Chemotherapy	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ N
Chest Pains	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ N
Cold Sores/Fever Blisters	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Ulcers	☐ Yes	☐ N
Congenital Heart Disorder	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Radiation Treatements	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ N
Convulsions	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ N

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dan gerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____