REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

SS#/Patient ID #_____

Patient Name_____

_____

Address_____

City_____State_____Zip_____

How Long?_____ Rent ☐ Own☐

E-mail_____

Sex ☐M ☐F Age_____

Birth Date_____

Driver's License #_____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered For____Years

Occupation_____

Patient Employer/School_____

How long at this employer/school?_____

Employer/School Address_____

Employer/School Phone_____

Spouse's Name_____

Spouse's Birth Date_____

Spouse's SS#_____

Spouse's Employer_____

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

Subscriber's Name_____

Birth Date_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Insurance Assignment

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

with_____and assign directly to

Name of insurance company(ies)

Dr._____

all insurance benefits, if any, otherwise payable to me for services rendered.

Financial and Personal Health Information

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information for treatment, payment and health care operations. This consent will end when my current 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 (_____)_____

4 CREDIT REFERENCES

Name of Bank_____ Branch_____

Bank Cards (VISA/MC)_____ Gas Cards_____

_____ Store Account or Other_____

_____ _____

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
Sore or growths in your mouth	☐Yes	☐No

How often do you floss?_____
How often do you brush?_____

6 HEALTH HISTORY

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

AIDS/HIV	☐Yes	☐No
Anemia	☐Yes	☐No
Arthritis, Rheumatism	☐Yes	☐No
Artificial Heart Valves	☐Yes	☐No
Artificial Joints	☐Yes	☐No
Asthma	☐Yes	☐No
Back Problems	☐Yes	☐No
Bleeding abnormally, with extractions or surgery	☐Yes	☐No
Blood Disease	☐Yes	☐No
Cancer	☐Yes	☐No
Chemical Dependency	☐Yes	☐No
Chemotherapy	☐Yes	☐No
Circulatory Problems	☐Yes	☐No
Congenital Heart Lesions	☐Yes	☐No
Cortisone Treatments	☐Yes	☐No
Cough, Persistent/Bloody	☐Yes	☐No
Diabetes	☐Yes	☐No
Emphysema	☐Yes	☐No
Epilepsy	☐Yes	☐No
Fainting or Dizziness	☐Yes	☐No
Glaucoma	☐Yes	☐No
Headaches	☐Yes	☐No
Heart Murmur	☐Yes	☐No
Heart Problems	☐Yes	☐No
Hepatitis Type_____	☐Yes	☐No
Herpes	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Jaundice	☐Yes	☐No
Jaw Pain	☐Yes	☐No
Kidney Disease	☐Yes	☐No
Liver Disease	☐Yes	☐No
Low Blood Pressure	☐Yes	☐No
Mitral Valve Prolapse	☐Yes	☐No
Nervous Problems	☐Yes	☐No
Pacemaker	☐Yes	☐No
Psychiatric Care	☐Yes	☐No
Radiation Treatment	☐Yes	☐No
Respiratory Disease	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No
Scarlet Fever	☐Yes	☐No
Shortness of Breath	☐Yes	☐No
Sinus Trouble	☐Yes	☐No
Skin Rash	☐Yes	☐No
Special Diet	☐Yes	☐No
Stroke	☐Yes	☐No
Swollen Feet or Ankles	☐Yes	☐No
Swollen Neck Glands	☐Yes	☐No
Thyroid Problems	☐Yes	☐No
Tonsillitis	☐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

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:_____

_____

_____

Pharmacy Name_____

Phone (___)_____

ALLERGIES

☐Aspirin
☐Barbiturates (Sleeping pills)
☐Codeine
☐Iodine
☐Latex
☐Local Anesthetic
☐Penicillin
☐Sulfa
☐Other_____

_____