

DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

Date _____ Home Phone (_____) _____ Cell Phone (_____) _____

PATIENT INFORMATION

Name			SS/HIC/Patient ID #			
Last Name	First Name	Middle Initial				
Address			E-mail			
City			State	Zip		
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	Birthdate	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Single	<input type="checkbox"/> Minor
			<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Partnered for _____ years	
Patient Employer/School			Occupation			
Employer/School Address			Employer/School Phone (_____) _____			
Whom may we thank for referring you?						
In case of emergency who should be notified?			Phone (_____) _____			

PRIMARY INSURANCE

Person Responsible for Account					
Last Name	First Name	Middle Initial			
Relation to Patient	Birthdate	Soc. Sec. #			
Address (If different from patient's)			Phone (_____) _____		
City			State	Zip	
Person Responsible Employed by			Occupation		
Business Address			Business Phone (_____) _____		
Insurance Company					
Contract #	Group #	Subscriber #			
Names of other dependents covered under this plan					

ADDITIONAL INSURANCE

Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Subscriber Name			Relation to Patient		
Address (If different from patient's)			Phone (_____) _____		
City			State	Zip	
Subscriber Employed by			Business Phone (_____) _____		
Insurance Company					
Contract #	Group #	Subscriber #			
Names of other dependents covered under this plan					

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(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. 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 doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. 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

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

DENTAL HEALTH HISTORY

(Confidential)

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity to hot
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> Sensitivity to cold	<input type="checkbox"/> Sores or growths in your mouth

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

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Physician's Phone Number _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Atonal, Alevia, Dioronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) Yes No

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

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

Yes No	Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> <input type="checkbox"/> Cough up Blood	<input type="checkbox"/> <input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> <input type="checkbox"/> Skin Rash
<input type="checkbox"/> <input type="checkbox"/> Artificial Joints	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Jaw Pain	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Swelling of Feet or Ankles
<input type="checkbox"/> <input type="checkbox"/> Back Problems	<input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> <input type="checkbox"/> Blood Disease	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Tonsillitis
<input type="checkbox"/> <input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Heart Problems	<input type="checkbox"/> <input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> <input type="checkbox"/> Ulcer
<input type="checkbox"/> <input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease

MEDICATIONS

ALLERGIES

List medications you are currently taking: _____

Pharmacy Name _____

Phone (____) _____

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Codeine	
<input type="checkbox"/> Local Anesthetic	
<input type="checkbox"/> Penicillin	
<input type="checkbox"/> Sulf	

SIGNATURE

The above information is accurate and complete to the best of my knowledge, I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____