DENTAL REGISTRATION & HISTORY

PATIENT INFORMATION

Name _____ How would you like to be addressed? _____
Last First Middle

Address _____ City _____ State _____ Zip _____
Home # (___)_____ Work # (___)_____Cell # (___)_____ E-Mail _____

☐Single ☐ Married ☐ Widowed ☐Separated ☐Divorced ☐Partnered for _____years ☐ Minor

Birthdate _____ Age_____ SS# _____ Sex ☐ M ☐ F

Patient Employer_____ Occupation _____

Employer Address _____

Spouse's Name _____ Birthday _____ SS# _____

Spouse's Employer _____ Work # (___)_____

DENTAL INSURANCE

Who is responsible for this account? _____ Relationship to patient _____
Insurance Company _____ ID# _____ Group # _____

Is patient covered by additional insurance? ☐Yes ☐No
Subscriber's name _____ Relationship to patient _____
Subscriber's birthdate _____ SS# _____
Insurance Company _____ ID# _____ Group # _____

ASSIGNMENT & 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 dentist 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.

_____ Date _____
Signature of Patient, Parent, Guardian or Personal Representative

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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 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/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 object	☐Yes ☐No	
Grinding teeth	☐Yes ☐No	
Gums swollen or tender	☐Yes ☐No	
Loose teeth or broken fillings	☐Yes ☐No	
Jaw pain or tiredness	☐Yes ☐No	
Lip or cheek biting	☐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	☐Yes ☐No	

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

- OVER -

DENTAL REGISTRATION & HISTORY

Health History

Are you under the care of a physician? ☐Yes ☐No If yes, for what condition? _____
Physician Name _____ Phone # _____ Date of last visit _____
Has there been any change in your general health within the past year? ☐Yes ☐No If yes, what condition _____
Have you had a serious illness, operation, or been hospitalized in the past 5 years? ☐Yes ☐No
If yes, what was the illness or problem? _____
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 ever taken alendronate, (Fosomax) or risedronate (Actonel) for osteoporosis or Paget's disease? ☐Yes ☐No
Were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia or Zometa)? ☐Yes ☐No
Do you use controlled substances (drugs)? ☐Yes ☐No
Do you drink alcoholic beverages? ☐Yes ☐No If yes, how much did you drink in the last 24 hours? _____ In a week? _____

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

AIDS/HIV	☐Yes ☐No	Epilepsy	☐Yes ☐No	Respiratory disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting or dizziness	☐Yes ☐No	Rheumatic fever	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Glaucoma	☐Yes ☐No	Scarlet fever	☐Yes ☐No
Artificial heart valve	☐Yes ☐No	Headache	☐Yes ☐No	Shortness of breath	☐Yes ☐No
Artificial joints	☐Yes ☐No	Heart murmur	☐Yes ☐No	Sinus trouble	☐Yes ☐No
Asthma	☐Yes ☐No	Heart problems	☐Yes ☐No	Skin rash	☐Yes ☐No
Back problems	☐Yes ☐No	Hepatitis Type _____	☐Yes ☐No	Special diet	☐Yes ☐No
Bleeding abnormally, with extractions or surgery	☐Yes ☐No	Herpes	☐Yes ☐No	Stroke	☐Yes ☐No
Blood disease	☐Yes ☐No	High blood pressure	☐Yes ☐No	Swollen feet or ankles	☐Yes ☐No
Cancer	☐Yes ☐No	Jaundice	☐Yes ☐No	Swollen neck glands	☐Yes ☐No
Chemical dependency	☐Yes ☐No	Jaw pain	☐Yes ☐No	Thyroid problems	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Kidney disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Circulatory problems	☐Yes ☐No	Liver disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Congenital heart lesions	☐Yes ☐No	Low blood pressure	☐Yes ☐No	Tumor/growth on head/neck	☐Yes ☐No
Cortisone treatments	☐Yes ☐No	Mitral valve prolapse	☐Yes ☐No	Ulcer	☐Yes ☐No
Cough, persistent or bloody	☐Yes ☐No	Nervous problems	☐Yes ☐No	Venereal disease	☐Yes ☐No
Diabetes	☐Yes ☐No	Pacemaker	☐Yes ☐No	Weight loss, unexplained	☐Yes ☐No
Emphysema	☐Yes ☐No	Psychiatric care	☐Yes ☐No	Do you wear contact lenses?	☐Yes ☐No

Women:
Are you pregnant? ☐Yes ☐No Due date: _____ Are you nursing? ☐Yes ☐No Taking birth control? ☐Yes ☐No

MEDICATIONS

List any medications, vitamins, natural or herbal preparations and/or diet supplements you are currently taking and the correlating diagnosis: _____
_____
_____
_____
Pharmacy Name: _____
Phone: (_____)_____

ALLERGIES

☐Aspirin
☐Barbituates (sleeping pills)
☐Codeine
☐Iodine
☐Latex
☐Local Anesthesia
☐Penicillin
☐Sulfa
☐Other _____
_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient/parent/guardian _____ Date _____