

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____ city _____ state _____ zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Weight _____ Height _____

Patient/Parent Information:

Patient/Parent SS# _____

Name _____ Employer _____

Employer Address _____ Phone _____

Spouse's Name _____ Employer _____

SS# _____ DOB _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____ Relation to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____ Group# _____

Employer _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or any dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable by me for services rendered. I authorize the use of this signature on all insurance submissions.

_____ Responsible Party Signature Relationship Date

3 PHONE NUMBERS

Home _____ Work _____ Ext _____ Spouse's Work _____

Best time and place to reach you _____ Cell# _____

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

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____	Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear dentures? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> full <input type="checkbox"/> partial	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
What is your chief dental complaint _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you apprehensive about dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever used Nitrous Oxide (Laughing Gas)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to use Nitrous Oxide for dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____

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MEDICAL HISTORY

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

Acid Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Due date _____		
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Physician Name: _____		
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Phone: _____		
Back Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you presently under the care of a physician?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Abnormally, with extraction or surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Why? _____		
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date last visited physician _____		
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	*please list other medical conditions not mentioned in the above _____		
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Circulatory problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Congenital Heart Lesions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Cortisone Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you been hospitalized?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Give reasons & dates _____		
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Fainting or dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any pins, plates or metal implants placed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please explain _____		
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
			Tumor or Growth on head or neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

MEDICATIONS

List all medications you are currently taking:

Pharmacy Name _____ Phone _____

ALLERGIES

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Lidocaine |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfas |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Other _____ |

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 payments and/or payment of benefits.

Responsible Party _____ Date _____

Relationship _____