ADULT DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Patient Name: ____ Date:____________________
Last First MI

Preferred Name :_____________ Sex: ☐ Male ☐ Female / ☐ Married ☐ Single ☐ Child ☐ Other______________

Social Security #: _______________ Birth Date:_____________ Age:____ Driver's License#:____________________

Phone (Home): _______________ (Work): _______________ Ext:______ Best time to call:____________________

Other Phone:____________________ E-mail Address:____

Address: ____
Street Apt.# City State Zip Code

EMPLOYMENT INFORMATION

The following is for the patient:

Employer Name: __________________________________ Occupation: ______________________________

Address:____ Phone:_______________
Street City State Zip Code

EMERGENCY CONTACT

Name:____ Relationship:_____________________________

Home Phone:___________________ Work Phone:___________________ Other Phone:____________________

HEALTH INFORMATION

Date of Last Dental Visit: _________________ Reason for this visit:__________________________________

Former Dentist:_________________________ City/State:____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Cortisone treatments
- ☐ Cough, bloody
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hepatitis type_______
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV positive
- ☐ Jaundice
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Nervous disorder
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Rheumatism
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin rash
- ☐ Special diet
- ☐ Stroke
- ☐ Swelling of ankles/feet
- ☐ Swollen neck glands
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor/growth on head/neck
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Weight loss, unexplained

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ **LATEX**
- ☐ Local anesthetic
- ☐ **PENICILLIN**
- ☐ Sulfa
- ☐ Other________________

____
____

Other Medical History /Conditions

____
____
____
____
____
____

Do you wear contact lenses? ☐ Yes ☐ No

Do you premedicate for Heart Problems, Artificial Joints, etc. ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_________________________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

DENTAL HISTORY

Please check all that apply:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain when brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sore/growths in mouth
- ☐ How often do you floss___________
- ☐ How often do you brush___________

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

Pharmacy Name:___________________________ Phone:__________________ Physician's Name:______________________

SPOUSE INFORMATION

The following is for the patient's spouse:

Spouse's Name: ____
Last First MI

Preferred Name :__________________ ☐ Male ☐ Female

Social Security #: _______________ Birth Date:______________ Driver's License#:______________________________

Phone (Home): ________________ (Work): ________________ Ext:______ Best time to call:_____________________

Other Phone:________________________ E-mail Address:____

Address:____
Street Apt.# City State Zip Code

DENTAL INSURANCE INFORMATION

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #:_____________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name/Address: ____

Name of Insurance company:____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other___________________

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #:_____________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name/Address: ____

Name of Insurance Company:____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other___________________

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other__________________

Name of person or office referring you to our practice:____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: _____________ Relationship to Patient: ___________________________
Signature of patient, parent or guardian

____ Date: _____________ Relationship to Patient: ___________________________
Signature of guarantor of payment/responsible party