REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Date Employed and ID # _____

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Address _____

Phone _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

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 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. 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 DENTAL HISTORY

Reason for today's visit _____

_____

May we contact your prior dentist? _____

If so, name _____

Address _____

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	Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
			Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
			Chewing Tobacco	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	How often do you floss? _____		
			Lip or cheek biting	☐ Yes	☐ No	How often do you brush? _____		

– O V E R –

5 HEALTH HISTORY

Physician's Name_____ Date of last visit _____

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

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

Artificial Heart Valves	☐ Yes	☐ No	Chemical Dependency	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Circulatory Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Cortisone Treatments	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Cough, persistent or bloody	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Alcohol, Cocaine or other drug use?	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
			Kidney Disease	☐ Yes	☐ No			
Blood Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Weight Loss, unexplained	☐ 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 pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the reason why:

_____

_____

_____

Do you need to be premedicated? If so, why? _____

Have you ever taken the following?:

Diet Medications: ☐ Dexfenfluramine ☐ Fen-phen ☐ Pondimin ☐ Redux

Blood thinners: ☐ Coumadin ☐ Warfarin

Other: ☐ Levoxyl ☐ Synthroid

Any Osteoporosis medications such as:

☐ Bisphosphorates (Fosomax, Boniva, Actonel)

Pharmacy Name_____

Phone (_____)_____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____