# 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

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

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 _____

_____

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 have 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, or 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 objects | ☐ Yes | ☐ No |
| Grinding teeth | ☐ Yes | ☐ No |
| Gums swollen or tender | ☐ Yes | ☐ No |
| Jaw pain or tiredness | ☐ Yes | ☐ No |
| Lip or cheek biting | ☐ Yes | ☐ No |
| Loose teeth or broken fillings | ☐ 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 in your mouth | ☐ Yes | ☐ No |

How often do you floss? _____

How often do you brush? _____

## 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:

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

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

## ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

## 6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____