

DENTAL REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID# _____

Patient Name _____
Last Name

_____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for ___ years

Patient Employer/School _____

Occupation _____

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

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

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 _____	Burning sensation on tongue	Yes	No	Mouth breathing	Yes	No
_____	Chew on one side of mouth	Yes	No	Mouth pain, brushing	Yes	No
Former Dentist _____	Cigarette, pipe, or cigar smoking	Yes	No	Orthodontic treatment	Yes	No
City/State _____	Clicking or popping jaw	Yes	No	Pain around ear	Yes	No
Date of last dental visit _____	Dry mouth	Yes	No	Periodontal treatment	Yes	No
Date of last dental X-rays _____	Fingernail biting	Yes	No	Sensitivity to cold	Yes	No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth	Yes	No	Sensitivity to heat	Yes	No
Bad breath Yes No	Foreign objects	Yes	No	Sensitivity to sweets	Yes	No
Bleeding gums Yes No	Grinding teeth	Yes	No	Sensitivity when biting	Yes	No
Blisters on lips or mouth 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? _____		

5

HEALTH HISTORY

Physician's Name _____ Date of last visit. _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

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	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 Valves	Yes	No	Headaches	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 or growth on head or neck	Yes	No
Cortisone Treatments	Yes	No	Mitra! 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	Radiation Treatment	Yes	No			

MEDICATIONS

ALLERGIES

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

Pharmacy Name _____

Phone (_____) _____

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 _____