

DENTAL REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

Patient _____

Address _____

City State Zip

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

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. _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. 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 _____

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

Name _____ Relationship _____

Home Phone _____ Work Phone _____

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MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone _____

ALLERGIES

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

Reason for Today's Visit:

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HEALTH HISTORY

Physician's Name _____ Date of Last Visit _____

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

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Abnormally with		Type _____		Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extractions or Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, Persistent or		Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or Growth	
Bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	on Head or Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women: Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Due Date _____			

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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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning Sensation on Tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose Teeth or Broken Fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on One Side of Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips/mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette, pipe, or Cigar Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Pain, Brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Clicking or Popping Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Around Ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Fingernail Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Food Collection Between the Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Foreign Objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Grinding Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Gums Swollen or Tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Jaw Pain or Tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores/Growths in Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Lip or Cheek Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss?	_____
				How often do you brush?	_____

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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? _____

Parent's Signature _____ Date _____

Doctor's Signature _____ Date _____