

DENTAL REGISTRATION AND HISTORY

Patient Information

Name _____
Last First Middle Initial

Home Phone (____) _____ Cell (____) _____

Email _____ SSN _____
(Social Security Number)

Address _____
Street

City _____

State _____ Zip Code _____

Sex M F Age _____ Birthdate _____

Marital Status:

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Spouse's Name _____

Cell (____) _____ Birthdate _____

SSN _____
(Social Security Number)

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

Name _____
Last Name First Name Middle Initial

Relationship to patient _____

Home Phone (____) _____ Cell (____) _____

Insurance Information

Primary

Name of Insured _____
Last First MI

Is insured a patient? Yes No

Insured's Birth Date _____ ID # _____ Group # _____

Insured's Address _____
Street

City _____

State _____ Zip Code _____

Insured's Employer Name _____

Address _____

City _____

State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address _____

Secondary

Name of Insured _____
Last First MI

Is insured a patient? Yes No

Insured's Birth Date _____ ID # _____ Group # _____

Insured's Address _____
Street

Insured's Employer Name _____

Address _____

City _____

State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with (Name of Insurance Company) _____ 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 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 _____

Dental History

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____ Date of last dental X-rays _____

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

- | | | | |
|-----------------------------------|--|--------------------------------|--|
| Bad Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw pain or tiredness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Gums | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lip or cheek biting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blisters on lips or mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loose teeth or broken fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning sensation on tongue | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chew on one side of mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain, brushing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cigarette, pipe, or cigar smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking or popping jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fingernail biting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No

How often do you floss? _____

How often do you brush your teeth? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

Health History

Physician's Name _____ Date of last visit _____

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

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionamin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) Yes No

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

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No

- | | | | |
|--|--|---------------------------------|--|
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you wear contact lenses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you ever had any complications following dental treatment? Yes No

If yes, please explain _____

Have you been admitted to a hospital or needed emergency care during the past 2 years? Yes No

If yes, please explain _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain _____

Medications

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

Pharmacy Name _____ Phone (_____) _____

Allergies

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