DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

First Name_____M.I._____Last Name_____Preferred Name_____

Address_____City_____State_____Zip Code_____

Home Phone (_____)_____Cell Phone (_____)_____ Work Phone (_____)_____

E-mail_____Age_____ Birthdate_____ Sex ☐ M ☐ F

Social Security #_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for_____Yrs

Patient Employer/School_____Occupation_____

Employer/School Address_____Employer/School Phone_____

Whom may we thank for referring you?_____

Notify in case of emergency_____HomePhone (____)_____Cell Phone (____)_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐Other_____

(If self skip to next section)

Name_____S.S#_____Birthdate_____Age_____

Address_____City_____State_____Zip Code_____

Home Phone (_____)_____Cell Phone (_____)_____ Work Phone (_____)_____

Employer _____Work Phone (____)_____

SPOUSE OF OTHER GUARANTOR INFORMATION (IF DIFFERENT FORM ABOVE

Name_____S.S#_____Birthdate_____Age_____

Address_____City_____State_____Zip Code_____

Home Phone (_____)_____Cell Phone (_____)_____ Work Phone (_____)_____

Employer _____Work Phone (____)_____

INSURANCE INFORMATION

Student: ☐ Full Time ☐ Part Time ☐ Not School Name/Address_____

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not _____

PRIMARY DENTAL INSURANCE COMPANY

Employer_____

Employer Address_____

Employer Phone (_____)_____

Ins. Co. Name_____

Ins. Address_____

Ins. City_____State_____Zip_____

Ins. Phone # (_____)_____

Subscriber I.D.#_____

Subscriber Name_____

Subscriber S.S#_____

Subscriber Relation to Patient_____

Subscriber Sex M F Birthdate_____

Subscriber Address_____

City_____State_____Zip_____

Subscriber Phone (_____)_____

SECONDARY DENTAL INSURANCE COMPANY

Employer_____

Employer Address_____

Employer Phone (_____)_____

Ins. Co. Name_____

Ins. Address_____

Ins. City_____State_____Zip_____

Ins. Phone # (_____)_____

Subscriber I.D.#_____

Subscriber Name_____

Subscriber S.S#_____

Subscriber Relation to Patient_____

Subscriber Sex M F Birthdate_____

Subscriber Address_____

City_____State_____Zip_____

Subscriber Phone (_____)_____

DENTAL INFORMATION

Reason for today's visit: Exam Consultation Emergency Are you in pain? Yes No For how Long?_____

Please indicate any of the following problems by checking off the corresp9onding box:

☐ Bad Breath
☐ Red, Swollen or Bleeding Gums
☐ Discomfort, clicking or popping in jaw
☐ Food Caught Between Teeth
☐ Grinding or Clenching Teeth
☐ Loose or Shifting Teeth
☐G um Disease
☐ Blisters/sores in or around the mouth
☐ Lost/Broken Filling
☐ Broken/Chipped Tooth
☐ Burning tongue/lips
☐ Swelling/Lumps in mouth
☐ Recent infection or sore throat
☐ Stained teeth
☐ Locking jaw
☐ Difficulty closing jaw
☐ Difficulty opening jaw
☐ Toothache Location_____

My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting ☐ Other:_____

Last dental exam_____Last dental x-rays_____Times a day you brush_____Times a week you floss_____

How do you feel about the appearance of your teeth?_____

Other information about your dental health or previous treatment_____

MEDICAL INFORMATION

Physician's Name_____Phone_____

Date of last visit_____Have you ever had any serious illnesses or operations? ☐ Y ☐ N

If yes, please describe_____

Are you currently under physician care? ☐ Y ☐ N If yes, describe_____

Women: Is there a possibility of pregnancy? ☐ Y ☐ N Expected Delivery Date_____

Are you nursing? ☐ Y ☐ N Are you taking birth control pills? ☐ Y ☐ N

Check ( ) if you have or have had any of the following:

☐AIDS/HIV Positive
☐Anaphylaxis (allergic reaction)
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial heart valves
☐ Artificial Joints (ex knee, hip…)
☐ Asthma
☐ Atopic (Allergy prone)
☐ Back Problems
☐ Blood Disease
☐ Bronchitis
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Chest Pain/Angina
☐ Chew Tobacco
☐ Circulatory Problems
☐ Contact Lenses
☐ COPD
☐ Cortisone treatments
☐ Cough, Persistent
☐ Cough Up Blood
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fainting
☐ Food Allergies
☐ Glaucoma
☐ Hay Fever/Sinus Problems
☐ Headaches
☐ Heart Attack(s)
☐ Heart murmur
☐ Heart Problems (Describe)
☐ Hemophilia/Abnormal Bleeding
☐ Herpes
☐ Hepatitis
☐ High Blood Pressure
☐ Infectious Mononucleosis
☐ Jaw Pain
☐ Kidney Disease or malfunction
☐ Dialysis
☐ Liver Disease/Jaundice
☐ Malignant Hyperthermia
☐ Material allergies (latex, wool, metal, chemicals)
☐ Mitral valve prolapse
☐ Nervous Problems
☐ Pacemaker/Heart Surgery
☐ Psychiatric Care
☐ Rapid weight gain or loss
☐ Radiation treatment
☐ Respiratory Disease
☐ Rheumatic/Scarlet Fever
☐ Shingles
☐ Shortness of Breath
☐ Skin Rash
☐ Smoke
☐ Spina Bifida
☐ Stroke
☐ Surgical Implant
☐ Swelling or Feet or Ankles
☐ Thyroid Disease of Malfunction
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer/Colitis
☐ Venereal Disease

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

☐ Blood Thinners(Coumadin, Aspirin)
☐ Pain Killers (including aspirin)
☐ Tranquilizers
☐ Muscle Relaxers
☐ Insulin
☐ Stimulants
☐ Antidepressants
☐ Any bone density medications or Bisphosphonates (Boniva, Actonel, Fosamax, Aredia, Zometa)

Please list any other medications you are taking (including natural and herbal)

_____

_____

Are you allergic to or had a reaction to:

☐ Latex
☐ Penicillin
☐ Amoxicillin
☐ Codeine or other narcotics
☐ Valium
☐ Soy
☐ Sulfa Drugs
☐ Aspirin
☐ Eggs/Yolk
☐ Local Anesthetic (Numbing med)

Please list any other medications, antibiotics or non drug related allergies:

_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature of Patient:
(Parent or Guardian if minor) _____Date:_____

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. All patients are expected to pay for services when rendered. Payment may be made by: Cash, Check, VISA, and MasterCard. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys' fees, and court costs.

Signature of patient: (Parent or Guardian if minor) X_____Date:_____ ___

This signature on file is my authorization for the release of information necessary to process my claim. I herby authorize payment to this doctor names of the benefits otherwise payable to me.

Signature of patient: (Parent or Guardian if minor) X_____Date:_____