# DENTAL REGISTRATION AND HEALTH HISTORY

(PLEASE PRINT)

## PATIENT INFORMATION

Date _____ Home Phone _____ Cell/Message _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ Birth Place _____ ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse or Parent's Name _____ Address & Phone (if different) _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Relationship to Patient _____ Phone _____

## DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____ City _____ State _____

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

Are you happy with your smile? _____ Would you like to change anything? _____

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

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Grinding teeth or Clenching
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Food collection between teeth
- ❑ Sores or growths in your mouth
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Orthodontia
- ❑ Head, Neck or Jaw Injury
- ❑ Are You Nervous

How often do you floss? _____ How often do you brush? _____

## MEDICAL HISTORY

Physician's Name _____ Phone # _____ Date of Last Visit _____

Are you under Medical treatment now? _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

Have you ever taken Fosamax, Zometa or Aredia? _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

- ❑ AIDS
- ❑ Angina
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Diabetes
- ❑ Epilepsy / Seizures
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur / Type _____
- ❑ Heart Problems Describe _____
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

## MEDICATIONS

List medications you are currently taking (include non-prescription meds):

_____

_____

Pharmacy Name _____ Phone _____

## ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

## RESPONSIBLE PARTY

Person Responsible for Account _____ Relationship to Patient _____

Drivers Lic # _____ Birthdate _____ Soc. Sec. # _____

Address (if different from Patient's) _____ Home Phone _____ Cell Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Effective Date _____

ID # _____ Group # _____

Names of other dependents covered under this plan _____

## ADDITIONAL INSURANCE

Is patient covered by additional dental insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from Patient's) _____

Phone _____ SS # _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ ID # _____ Group # _____

Names of other dependents covered under this plan _____

## ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. Rheuben 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 to Patient | Date

## SIGNATURE

Thank you for selecting our office for your dental treatment. Our office has general guidelines to assist us in providing the best dental treatment. We ask that you review these general guidelines listed below.

1. There are no facilities for unattended children. If you have small children, please do not leave them unattended in the waiting room.
2. Fees are charged for all services and are determined by the type of dental treatment.
3. Payment for dental treatment is expected at the completion of each appointment.
4. Patients changing or cancelling appointments with less than 24 hours notice will be charged $50.00 per ½ hour scheduled.
5. A responsible parent or guardian must accompany minor patients (18 years or under) for all examinations and appointments.
6. I consent to the use of dental treatment procedures and anesthetics deemed necessary by Dr. Rheuben for my dental treatment.
7. I have read the preceding information and agree to abide with the above policies.

Date _____ Signed _____

(In case the patient is a minor)

I am signing for (Minor Patient's Name) _____