DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

First Name ____________ M.I. ______ Last Name ____________ Legal Name ____________

Home Phone (___) ____________ Cell Phone (___) ____________ Work Phone (___) ____________

Address ____________ E-mail ____________

City ____________ State ____________ Zip Code ____________

Sex ☐ M ☐ F Age _____ Birthdate ____________ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Social Security # ____________ ☐ Separated ☐ Divorced ☐ Partnered for _____ yrs

Patient Employer/School ____________ Occupation ____________

Employer/School Address ____________ Employer/School Phone (___) ____________

Whom may we thank for referring you? ____________

In case of emergency who should be notified? ____________ Phone (___) ____________

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ____________

(If self, skip to next section)

Name ____________ S.S.# ____________ Birthdate ____________ Age _____ Tel. (___) ____________

Street ____________ City ____________ State ____________ Zip ____________

Employer ____________ Work Phone (___) ____________

Spouse or other guarantor information (if different from above)

Name ____________ Relation ____________ S.S. # ____________ Birthdate ____________ Age ____ Tel. (___) ____________

Street ____________ City ____________ State ____________ Zip ____________

Tel. (___) ____________ Employer ____________ Work Phone (___) ____________

INSURANCE INFORMATION

Student: ☐ Full Time ☐ Part Time ☐ Not School Name/Address ____________

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Do you belong to a PPO or HMO? ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE COMPANY

Insurance Type: ☐ Dental

Employer ____________

Work Address ____________

Work Phone (___) ____________

Ins. Co. Name ____________

Address ____________

____________ Tel. (___) ____________

Subscriber I.D. # ____________

Insured Party ____________ Relation ____________

Sex: ☐ M ☐ F Birthdate ____________

Street ____________

City, State, Zip ____________

Tel. (___) ____________ S.S. # ____________

SECONDARY DENTAL INSURANCE CO.

Insurance Type: ☐ Dental

Employer ____________

Work Address ____________

Work Phone (___) ____________

Ins. Co. Name ____________

Address ____________

____________ Tel.(___) ____________

Subscriber I.D. # ____________

Insured Party ____________ Relation ____________

Sex: ☐ M ☐ F Birthdate ____________

Street ____________

City, State, Zip ____________

Tel. (___) ____________ S.S. # ____________

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 corresponding box:

☐ Discomfort, clicking, or popping in jaw	☐ Lost/broken filling(s)	☐ Stained teeth	☐ Difficulty closing jaw
☐ Red, swollen or bleeding gums	☐ Teeth grinding/clenching	☐ locking jaw	☐ Difficulty opening jaw
☐ A removable dental appliance	☐ Ringing in ears	☐ Bad breath	☐ Loose/shifting teeth
☐ Blisters/sores in or around the mouth	☐ Broken/chipped tooth	☐ Burning tongue/lips	☐ Food caught btwn teeth
☐ Prolonged bleeding from an injury/extraction	☐ Gum disease	☐ Grind/clench teeth	☐ Swelling/lumps in mouth
☐ Recent infections or sore throat	☐ Toothache Location_______	☐ Other:_______________	

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

Last dental exam____________ Last dental x-rays_____________ Times a day you brush?______ Times a week you floss?______

What type of tooth bristles do you use? ☐ Soft ☐ Medium ☐ Hard How would you rate your smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

MEDICAL INFORMATION

Physician's Name ________________________________ Date of Last Visit ______________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ______________________

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y N	Y N	Y N	Y N
☐ ☐ Rheumatic fever	☐ ☐ Asthma	☐ ☐ Bleeding tendency	☐ ☐ Low blood sugar
☐ ☐ Mitral valve prolapse	☐ ☐ Hay fever/Sinus problems	☐ ☐ Jaundice/Liver disease	☐ ☐ Kidney trouble
☐ ☐ Heart murmur	☐ ☐ Snoring/Sleep apnea	☐ ☐ Hepatitis	☐ ☐ Are you on dialysis
☐ ☐ High blood pressure	☐ ☐ Respiratory problems	☐ ☐ Infectious mononucleosis	☐ ☐ Arthritis/Joint disease
☐ ☐ Low blood pressure	☐ ☐ Tuberculosis	☐ ☐ Gallbladder trouble	☐ ☐ Stomach ulcers
☐ ☐ Chest pain/Angina	☐ ☐ Emphysema	☐ ☐ Fainting spells	☐ ☐ Contagious diseases
☐ ☐ Heart attack(s)	☐ ☐ Do you smoke	☐ ☐ Convulsions/Epilepsy	☐ ☐ Delay in healing
☐ ☐ Irregular heart beat	☐ ☐ Do you use chewing tobacco	☐ ☐ Stroke	☐ ☐ Anemia
☐ ☐ Cardiac pacemaker	☐ ☐ Blood transfusion	☐ ☐ Thyroid trouble	☐ ☐ Tumor or growth
☐ ☐ Heart surgery	☐ ☐ Blood disorder	☐ ☐ Diabetes	☐ ☐ Radiation/Chemotherapy
☐ ☐ Bronchitis/Chronic cough	☐ ☐ Bruise easily	☐ ☐ A history of alcohol abuse	☐ ☐ Are you on a diet
☐ ☐ Chronic fatigue/Nightsweat	☐ ☐ A history of drug abuse	☐ ☐ Sexually transmitted diseases	☐ ☐ Contact lenses
☐ ☐ Mental health problems	☐ ☐ Eye disease/Glaucoma	☐ ☐ Swollen ankles	☐ ☐ Immune system problems
☐ ☐ Damaged heart valves	☐ ☐ Abnormal bleeding	☐ ☐ Malignant hyperthermia	
☐ ☐ Are you immunosuppressed? (possibly from transplant surg.)	☐ ☐ Problems w/immune system? (possibly from med./surg.)		

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

Y N	Y N	Y N	Y N
☐ ☐ Nerve pills	☐ ☐ Pain killers (including aspirin)	☐ ☐ Muscle relaxers	☐ ☐ Stimulants
☐ ☐ Have you ever taken diet pills	☐ ☐ Tranquilizers	☐ ☐ Insulin	☐ ☐ Antidepressants

☐ ☐ Blood thinners (Coumadin, Aspirin, Advil)

☐ ☐ Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

____

____

____

____

____

Are you allergic to or had a reaction to:

Y N	Y N	Y N	Y N
☐ ☐ Penicillin	☐ ☐ Sulfa drugs	☐ ☐ Local anesthetic (numbing med)	☐ ☐ Sodium pentothal
☐ ☐ Valium or other tranquilizers	☐ ☐ Aspirin	☐ ☐ Codeine or other narcotics	☐ ☐ Latex
☐ ☐ Soy	☐ ☐ Eggs/Yolk	☐ ☐ Sulfites	☐ ☐ Amoxicillin

Please list any other medication or antibiotic you are allergic to:

____

____

____

____

Please list any allergies other than drug allergies:

____

____

____

____

1-4 below for women only: (women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician/gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? ☐ Yes ☐ No

2) Expected delivery date: ____________________

3) Are you nursing? ☐ Yes ☐ No

4) Are you taking birth control pills: ☐ Yes ☐ No

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 doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient:
(Parent or Guardian if minor) X ______________________ Date: ______________ Review by: ______________

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, Mastercard, money order 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 hereby authorize payment to this doctor names of the benefits otherwise payable to me.

Signature of patient: (Parent or Guardian if minor) X ______________________ Date: ______________

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: (Parent or Guardian if minor) X ______________________ Date: ______________