

REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____
 SS# _____
 Patient Name _____
 Address _____
 City _____ State _____ Zip _____
 How Long? _____ Rent Own
 E-mail _____
 Sex M F Age _____
 Birth Date _____
 Married Widowed Single Minor
 Separated Divorced Partnered For _____ Years
 Occupation _____
 Spouse's Name _____
 Spouse's Birth Date _____
 Spouse's SS# _____
 Spouse's Employer _____
 Whom may we thank for referring you? _____

 Acknowledgement of Receipt of Notice of Privacy Policies
 I, _____, have received a copy of Kimberly F. Wilkins,
 D.M.D., Notice of Privacy Policies. I understand Dr. Wilkins may use my
 health care information and may disclose such information for treatment,
 payment, and health care operations.
 _____ Printed Name
 _____ Signature & Date _____

2 DENTAL INSURANCE

Who is financially responsible for this account?

 Relationship to Patient _____
 Insurance Co. _____
 Group# _____
 Is patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Birth Date _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____
Insurance Assignment
 I certify that I, and/or my dependents(s), have insurance coverage
 with _____ and assign directly to
Name of insurance company(ies)
 Dr. Kimberly F. Wilkins all insurance benefits, if any, otherwise payable to
 me for services rendered.
Financial and Personal Health Information
 I understand that I am financially responsible for all charges incurred during
 my treatment. I further understand that any insurance contract is between my
 insurance carrier and myself and that Dr. Wilkins is not a part of that contract. I also
 understand that Dr. Wilkin's office, as a courtesy, will file initial insurance forms on
 my behalf, and that office personnel will provide information to help me deal with
 my insurance carrier. If problems occur with the insurance portion of the obligation,
 I understand the balance in full will become due in 30 days. I also agree to be liable
 for all costs of collections (35-50%), including attorney's fees and court costs, and
 that finance charges will begin 60 days from the date of service if the balance is not
 paid in full. I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____
 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 (_____) _____

4 HEALTH HISTORY UPDATE

To be updated at your future dental visits

Date Of Visit	Changes To Health History / Medication	Detail Changes Initials
1. _____	YES _____ NO _____	_____
2. _____	YES _____ NO _____	_____
3. _____	YES _____ NO _____	_____

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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 Yes No
- Bleeding Gums Yes No
- Blisters on lips or mouth Yes No
- Burning sensation on tongue Yes No
- Chew on one side of mouth Yes No
- Cigarette, pipe, or cigar smoking Yes No
- Clicking or popping jaw Yes No
- Dry Mouth Yes No
- Fingernail Biting Yes No
- Food collection between the teeth Yes No

- Foreign Objects Yes No
- Grinding Teeth Yes No
- Gums swollen or tender Yes No
- Jaw pain or tiredness Yes No
- Lip or cheek biting Yes No
- Loose teeth or broken fillings Yes No
- Mouth Breathing Yes No
- Mouth pain, brushing Yes No
- Orthodontic Treatment Yes No
- Pain around ear Yes No
- Periodontal Treatment Yes No
- Sensitivity to cold Yes No
- Sensitivity to heat Yes No
- Sensitivity to sweets Yes No
- Sensitivity when biting Yes No
- Sore or growths in your mouth Yes No
- How often do you floss? _____
- How often do you brush? _____

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HEALTH HISTORY

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

- | | | |
|---|--|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease <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 | Rheumatic Fever <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 | Scarlet Fever <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 | Shortness of Breath <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 | Sinus Trouble <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 | Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type ____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <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 | Swollen Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, Persistent/Bloody <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <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 | Weight Loss (unexplained) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you, or do you suspect that you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | |

MEDICATIONS

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

Pharmacy Name _____

Phone (____) _____

ALLERGIES

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