151 Dixon Dental Care
Mel Dixon D.D. S.
151 W. Speedway
Tucson, AZ 85705

Dental Registration

Date: _____S.S.N._____

Patient Name_____

Nick Name_____

Address: _____

State/Zip_____

Home #_____

Work #_____

Cell #_____

Email address_____

Sex: M__F__ Age:____Birthdate_____

Single__Married__Widowed__Separated__Divorced_

Employer_____

School Enrolled _____

Occupation_____

Employer address_____

Spouse Name_____

Spouse work #_____

Spouse DOB_____Spouse SSN_____

Spouse Employer_____

Name of Insured_____

Insured DOB_____

Insured S.S.N._____

Insurance company_____

Insurance address_____

Insurance phone number_____

Insurance group number_____

Insurance ID_____

How did you hear about our office?_____

Emergency contact name & #_____

Dental History

Reason for today's visit_____

_____

Date of last dental visit_____

Date of last X-rays_____

How often do you floss?_____

How often do you brush?_____

When you brush your teeth, Do you have trouble reaching in-between your teeth & below the gum line?
Yes No

Please indicate if you *currently* have any of the following:

Bad breath	Yes	No
Bleeding gums	Yes	No
Gums swollen or tender	Yes	No
Periodontal treatment	Yes	No
Chew on one side of mouth	Yes	No
Cigarette, pipe or cigar smoking	Yes	No
Clicking or popping jaw	Yes	No
Lip or cheek biting	Yes	No
Blisters on mouth or lips	Yes	No
Sores or growths in mouth	Yes	No
Grinding teeth	Yes	No
Food collection between teeth	Yes	No
Loose teeth or broken fillings	Yes	No
Orthodontic treatment	Yes	No
Sensitive to hot or cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive when biting	Yes	No

Are your teeth as white as you would like? Yes No

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Health History

Please indicate if you have had any of the following:

AIDS/HIV	Yes	No
Anemia	Yes	No
Arthritis	Yes	No
Artificial Heart Valves	Yes	No
Artificial Joints	Yes	No
Asthma/Shortness of breath	Yes	No
Back Problems	Yes	No
Bleeding abnormally with extractions or surgery	Yes	No
Blood Disease	Yes	No
Cancer	Yes	No
Chemical dependency	Yes	No
Chemotherapy	Yes	No
Circulatory problems	Yes	No
Congenital heart lesions	Yes	No
Cough persistent or bloody	Yes	No
Diabetes	Yes	No
Emphysema	Yes	No
Epilepsy/Siezures	Yes	No
Fainting or dizziness	Yes	No
Headaches	Yes	No
Heart Murmur	Yes	No
Heart Problems	Yes	No
Hepatitis Type:	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
Jaw Pain	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Low Blood Pressure	Yes	No
Mitral Valve Prolapse	Yes	No
Nervous Problems	Yes	No
Pacemaker	Yes	No
Psychiatric Care	Yes	No
Radiation Treatment	Yes	No
Respiratory Disease	Yes	No
Skin rash	Yes	No
Stroke	Yes	No
Surgery With In 1 Year	Yes	No
TypeOfSurgery		
Swollen neck glands	Yes	No
Thyroid Problems	Yes	No
Tuberculosis	Yes	No
Tumor or growth on head or neck	Yes	No
Venereal Disease	Yes	No

Women:

Pregnant	Yes	No
Due Date:		
Taking birth control pills	Yes	No
Nursing	Yes	No
Other Conditions:		

Medications

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

_____

_____

Do you use antibiotic premedication prior to dental treatment _____Yes_____No

Physician's Name & Phone # :

_____

_____

Pharmacy Name & Cross Streets:

_____

_____

Allergies

Aspirin	Yes	No
Barbiturates	Yes	No
Codeine	Yes	No
Latex	Yes	No
Local Anesthesia	Yes	No
Penicillin	Yes	No

Other_____

☺ Failed appointments:

There will be a $50.00 charge for all failed appointments without 2 business days notice.

Assignment and Release I, the undersigned certify that I (or my dependant) have insurance coverage and assign directly to Dr. Dixon 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 this signature on all insurance submissions and all financing transactions, if applicable. In the unlikely event that your account becomes delinquent and our credit services intervene, please be advised there will be a charge for these services.

Signature:_____

Updates Office Use (List any changes, and initial)

Date)_____

_____