

# DENTAL REGISTRATION AND HISTORY

PLEASE PRINT • ANSWER ALL QUESTIONS

PATIENT INFORMATION	
Date _____	
SS/HIC/Patient ID # _____	
Patient Name _____	
Last Name	First Name
Middle Initial	
Address _____	
E-mail _____	
City _____	
State _____	Zip _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____
Birthdate _____	
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years	
Patient Employer/School _____	
Occupation _____	
Employer/School Address _____	
Employer/School Phone(_____) _____	
Spouse's Name _____	
Birthdate _____	
SS# _____	
Spouse's Employer _____	
Whom may we thank for referring you? _____	

DENTAL INFORMATION	
Who is responsible for this account? _____	
Relationship to Patient _____	
Insurance Co. _____	
Group # _____	
Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber's Name _____	
Birthdate _____	SS# _____
Relationship to Patient _____	
Insurance Co. _____	
Group # _____	
<b>ASSIGNMENT AND RELEASE</b>	
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____ Name of Insurance Company(ies)	
Dr. _____ 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 authorize the use of my signature on all insurance submissions.	
The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.	
_____ Signature of Patient, Parent, Guardian or Personal Representative	
_____ Please print name of Patient, Parent, Guardian or Personal Representative	
_____ Date	_____ Relationship to Patient

PHONE NUMBERS	
Phone (_____) _____	Work (_____) _____
Spouse's Work (_____) _____	Ext _____ Cell (_____) _____
Best time and place to reach you _____	
<b>IN CASE OF EMERGENCY, CONTACT</b> (Specify someone who does not live in your household.)	
Name _____	Relationship _____
Home Phone (_____) _____	Work Phone (_____) _____

## ACKNOWLEDGEMENT AND AUTHORITY

*I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate. The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing or processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE. In the event of default of payment your account will be turned over to a collection agency. I agree to pay all reasonable court costs, attorney fees and collection fees up to 50% of the delinquent balance.*

Date \_\_\_\_\_ Signature \_\_\_\_\_  
PATIENT, PARENT OR AGENT (MUST BE 18 YEARS OR OLDER)

## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelviz, Didronel, Boniva.  Yes  No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

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	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<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
Arthritis, Rheumatism	<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
Artificial Heart Valves	<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 Joints	<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
Asthma	<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
Back Problems	<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
Bleeding abnormally, with extractions or surgery	<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
Blood Disease	<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
Cancer	<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
Chemical Dependency	<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
Chemotherapy	<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
Circulatory Problems	<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
Congenital Heart Lesions	<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
Cortisone Treatments	<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
Cough, persistent or bloody	<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
Diabetes	<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
Do you wear contact lenses?	<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
		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Women:**

Are you pregnant?  Yes  No Due date \_\_\_\_\_ Are you nursing?  Yes  No

Taking birth control pills?  Yes  No

### MEDICATIONS

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

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

### ALLERGIES

<input type="checkbox"/> Asprin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

## DENTAL HISTORY

Reason for today's visit _____	Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tenderness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____	

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_