

DENTAL REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Birthdate _____ SS# _____

Patient Name _____
Last Name

First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Sex M F

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Why did you select our practice? _____

Whom may we thank for referring you? _____

Is another member of your family/relative a patient in our practice? _____

2

DENTAL INSURANCE

Insured person's full legal name _____

Relationship to Patient _____

Birthdate _____

SS # _____

Employer Name _____

Insurance Co. _____

Is patient covered by additional insurance? Yes No

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PHONE NUMBERS & CORRESPONDENCE

E-mail _____

Home (_____) _____

Work (_____) _____ Ext _____

Cell (_____) _____

Spouse's Name _____

Spouse's Work (_____) _____

IN CASE OF EMERGENCY, CONTACT
 (Specify someone who does not live in your household.)

Name _____

Relationship _____

Home (_____) _____

Work (_____) _____

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HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Apidex, 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 | 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 or 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 | |
| | Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No

Due Date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS	ALLERGIES
List any medications you are currently taking and the correlating diagnosis: _____ _____ Pharmacy Name _____ Phone (_____) _____	<input type="checkbox"/> Aspirin <input type="checkbox"/> Barbiturates (Sleeping Pills) <input type="checkbox"/> Codeine <input type="checkbox"/> Iodine <input type="checkbox"/> Latex <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____

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DENTAL HISTORY

Are your teeth sensitive to:

Heat? Yes No

Cold? Yes No

Sweets? Yes No

Biting Pressure? Yes No

Does food constantly get stuck between certain teeth in your mouth? Yes No

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? Yes No

If you could change anything about your smile, what would you change? _____

Are you dissatisfied with the way your teeth look? Yes No

For example: color, shape, spaces, etc. Yes No

Do you have any fillings that show in your front teeth? Yes No

If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? Yes No

Have you ever had any teeth removed? Yes No

How long have these teeth been missing? _____

Do you have any jaw pain or do you grind your teeth? Yes No

Do your gums bleed when brushing or flossing? Yes No

Do you ever avoid any part of your mouth when brushing? Yes No

Have you been instructed regarding proper home care? Yes No

Do you have an unpleasant taste or odor in your mouth? Yes No

Do you smoke or use tobacco? Yes No

Do you frequently snack between meals, or chew gum? Yes No

How often do you brush your teeth? _____

How often do you floss? _____

Do you want to learn to control dental disease and retain your teeth? Yes No

Has the fear of discomfort kept you from regular dental visits? Yes No

Are you deeply concerned about the finances required to return your mouth to excellent dental health? Yes No

When was your last dental appointment? _____

What did you have done? _____

How long since your last thorough examination with full mouth x-rays? _____

What prompted you to seek dental care this time? _____

Why did you leave your last dentist? _____

AUTHORIZATION AND RELEASE: I have read and answered the above questions to the best of my knowledge. This is to certify that I, the undersigned, consent to the performing of the dental care procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the dentist to release any information including the diagnosis and records, including radiographs, of any treatment or examination rendered to me during the period of such dental care to other health or dental care providers. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor

Date

Payment is due in full at time of treatment unless prior arrangements have been approved.