## DENTAL REGISTRATION AND HISTORY

| PATIENT INFORMATION |  |
| :---: | :---: |
| Date |  |
| SS/HIC/Patient ID \# |  |
| Patient Name |  |
| First Name | Middle Initial |
| Address |  |
| E-mail |  |
| City |  |
| State | Zip |
| Sex $\square \mathrm{M} \quad \square \mathrm{F}$ Age $\square$ |  |
| Birthdate |  |
| $\square$ Married $\square$ Widowed | $\square$ Single $\quad \square$ Minor |
| $\square$ Separated $\square$ Divorced | $\square$ 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 referrin | you? |

## DENTAL INSURANCE

Who is responsible for this account?
Relationship to Patient $\qquad$ Insurance Co. $\qquad$
Group \#
Is patient covered by additional insurance? $\square$ Yes $\square$ No
Subscriber's Name
Birthdate__SS\#
Relationship to Patient
Insurance Co.
Group \#
ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with
Name of Insurance Company(ies) and assign directly to
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 (_ ) $\qquad$ ) Ext $\qquad$ Cell $\qquad$ ) Best time and place to reach you $\qquad$ -
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)
Name
Relationship
Home Phone (_ ) Work Phone ( $\quad$ )

## 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:
$\begin{array}{ll}\text { Bad breath } & \square \text { Yes } \square \text { No } \\ \text { Bleeding gums } & \square \text { Yes } \square \text { No } \\ \text { Blisters on lips or mouth } & \square \text { Yes } \square \text { No }\end{array}$

| Burning sensation on tongue | $\square$ Yes $\square$ No |
| :--- | :--- | :--- |
| Chew on one side of mouth | $\square$ Yes $\square$ No |
| Cigarette, pipe, or cigar smoking | $\square$ Yes $\square$ No |
| Clicking or popping jaw | $\square$ Yes $\square$ No |
| Dry mouth | $\square$ Yes $\square$ No |
| Fingernail biting | $\square$ Yes $\square$ No |
| Food collection between the teeth | $\square$ Yes $\square$ No |
| Foreign objects | $\square$ Yes $\square$ No |
| Grinding teeth | $\square$ Yes $\square$ No |
| Gums swollen or tender | $\square$ Yes $\square$ No |
| Jaw pain or tiredness | $\square$ Yes $\square$ No |
| Lip or cheek biting | $\square$ Yes $\square$ No |
| Loose teeth or broken fillings | $\square$ Yes $\square$ No |


| Mouth breathing | $\square$ Yes $\square$ No |  |
| :--- | :--- | :--- |
| Mouth pain, brushing | $\square$ Yes $\square$ No |  |
| Orthodontic treatment | $\square$ Yes $\square$ No |  |
| Pain around ear | $\square$ Yes $\square$ No |  |
| Periodontal treatment | $\square$ Yes $\square$ No |  |
| Sensitivity to cold | $\square$ Yes $\square$ No |  |
| Sensitivity to heat | $\square$ Yes $\square$ No |  |
| Sensitivity to sweets | $\square$ Yes $\square$ No |  |
| Sensitivity when biting | $\square$ Yes $\square$ No |  |
| Sores or growths in your mouth | $\square$ Yes $\square$ No |  |
| How often do you floss? |  |  |
| How often do you brush? |  |  |

Physician's Name $\qquad$ Date of last visit

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. $\square$ Yes $\square$ 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). $\square$ Yes $\square$ No
Place a mark on "yes" or "no" to indicate if you have had any of the following:


## MEDICATIONS

## ALLERGIES

| List any medications you are currently taking and the correlating diagnosis: | $\square$ Aspirin | $\square$ Local Anesthetic |
| :---: | :---: | :---: |
|  | $\square$ Barbiturates (Sleeping pills) | $\square$ Penicillin |
|  | $\square$ Codeine | $\square$ Sulfa |
| Pharmacy Name | $\square$ lodine | $\square$ Other |
| Phone ( | $\square$ Latex |  |
| UPDATES (To be filled in at future appointments) |  |  |
|  |  |  |
| Has there been any change in your health since your last d | pointment? $\square$ Yes $\square$ No |  |
| For what conditions? <br> Are you taking any new medications? $\qquad$ If so, what? |  |  |
|  |  |  |
| Patient's Signature__ Date_ |  |  |
| Doctor's Signature |  | Date |
| Has there been any change in your health since your last dental appointment? $\square$ Yes $\square$ No |  |  |
| For what conditions? |  |  |
| Are you taking any new medications? __ If so, what? |  |  |
| Patient's Signature |  | Date |
| Doctor's Signature |  | Date |

