# DENTAL REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ 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? _____

## 2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ 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 _____ 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

## 3 PHONE NUMBERS

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

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 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 | Burning sensation on tongue | ☐ Yes | ☐ No | Mouth breathing | ☐ Yes | ☐ No |
| Bleeding gums | ☐ Yes | ☐ No | Chew on one side of mouth | ☐ Yes | ☐ No | Mouth pain, brushing | ☐ Yes | ☐ No |
| Blisters on lips or mouth | ☐ Yes | ☐ No | Cigarette, pipe, or cigar smoking | ☐ Yes | ☐ No | Orthodontic treatment | ☐ Yes | ☐ No |
| | | | Clicking or popping jaw | ☐ Yes | ☐ No | Pain around ear | ☐ Yes | ☐ No |
| | | | Dry mouth | ☐ Yes | ☐ No | Periodontal treatment | ☐ Yes | ☐ No |
| | | | Fingernail biting | ☐ Yes | ☐ No | Sensitivity to cold | ☐ Yes | ☐ No |
| | | | Food collection between the teeth | ☐ Yes | ☐ No | Sensitivity to heat | ☐ Yes | ☐ No |
| | | | Foreign objects | ☐ Yes | ☐ No | Sensitivity to sweets | ☐ Yes | ☐ No |
| | | | Grinding teeth | ☐ Yes | ☐ No | Sensitivity when biting | ☐ Yes | ☐ No |
| | | | Gums swollen or tender | ☐ Yes | ☐ No | Sores or growths in your mouth | ☐ Yes | ☐ No |
| | | | Jaw pain or tiredness | ☐ Yes | ☐ No | How often do you floss? _____ | | |
| | | | Lip or cheek biting | ☐ Yes | ☐ No | | | |
| | | | Loose teeth or broken fillings | ☐ Yes | ☐ No | How often do you brush? _____ | | |

## 5 HEALTH HISTORY

Physician's Name _____ Date of last visit_____

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

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, 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 | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No | Respiratory Disease | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Fainting or dizziness | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Arthritis, Rheumatism | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Scarlet Fever | ☐ Yes ☐ No |
| Artificial Heart Valves | ☐ Yes ☐ No | Headaches | ☐ Yes ☐ No | Shortness of Breath | ☐ Yes ☐ No |
| Artificial Joints | ☐ Yes ☐ No | Heart Murmur | ☐ Yes ☐ No | Sinus Trouble | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Heart Problems | ☐ Yes ☐ No | Skin Rash | ☐ Yes ☐ No |
| Back Problems | ☐ Yes ☐ No | Hepatitis Type _____ | ☐ Yes ☐ No | Special Diet | ☐ Yes ☐ No |
| Bleeding abnormally, with extractions or surgery | ☐ Yes ☐ No | Herpes | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| | | High Blood Pressure | ☐ Yes ☐ No | Swollen Feet or Ankles | ☐ Yes ☐ No |
| Blood Disease | ☐ Yes ☐ No | Jaundice | ☐ Yes ☐ No | Swollen Neck Glands | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Jaw Pain | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No |
| Chemical Dependency | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No | Tonsillitis | ☐ Yes ☐ No |
| Chemotherapy | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Circulatory Problems | ☐ Yes ☐ No | Low Blood Pressure | ☐ Yes ☐ No | Tumor or growth on head or neck | ☐ Yes ☐ No |
| Congenital Heart Lesions | ☐ Yes ☐ No | Mitral Valve Prolapse | ☐ Yes ☐ No | | |
| Cortisone Treatments | ☐ Yes ☐ No | Nervous Problems | ☐ Yes ☐ No | Ulcer | ☐ Yes ☐ No |
| Cough, persistent or bloody | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No | Venereal Disease | ☐ Yes ☐ No |
| Diabetes | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No | Weight Loss, unexplained | ☐ Yes ☐ No |
| Emphysema | ☐ Yes ☐ No | Radiation Treatment | ☐ Yes ☐ 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

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

_____

_____

Pharmacy Name _____

Phone (_____) _____

## ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

## 6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____