DENTAL REGISTRATION AND HISTORY

1- PATIENT INFORMATION

Date _____

Patient Name_____

Address_____

_____

City State Zip

Sex ☐ M ☐ F Age _____ Birth date_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Spouse's Name _____

Spouse's Employer _____

Whom may we thank for referring you? _____

If patient is under the age of 25:

Full Time student? ☐ YES ☐ NO

School attending _____

2 – DENTAL INSURANCE

Do you have Dental Insurance? ☐Yes ☐No

If yes, please give insurance card to photocopy and fill out below.

--PRIMARY CARRIER—

Subscriber Name _____

Subscriber ID# _____

Subscribers Birth Date _____

Relationship of Patient to Subscriber _____

Insurance Co. _____

Group # _____

Union or Local # _____

Employer Name _____

Date employed _____

3 – PHONE NUMBERS

Home # _____ Work # _____ Cell #_____ E-Mail_____

Best Time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 – DENTAL HISTORY

Reason for todays visit _____

Former Dentist _____City_____State_____ Date of last visit_____ Date of late X-rays_____

Are you having pain or discomfort at this time? ☐Yes ☐No

Are you dissatisfied with the appearance of your teeth/smile? ☐Yes ☐No

Place a mark on "Yes" or "No" to indicate if you have or have had any of the following:

Bleeding gums	☐Yes ☐No	Clicking/Popping Jaw	☐Yes ☐No	Sensitive to sweets	☐Yes ☐No
Difficulty in chewing	☐Yes ☐No	Grinding teeth	☐Yes ☐No	Sensitive when biting	☐Yes ☐No
Lip or cheek biting	☐Yes ☐No	Jaw pain	☐Yes ☐No	Sores on lips or mouth	☐Yes ☐No
Dry Mouth	☐Yes ☐No	Ear Pain	☐Yes ☐No	Shifting of teeth	☐Yes ☐No
Food between teeth	☐Yes ☐No	Orthodontic treatment	☐Yes ☐No	Tobacco use	☐Yes ☐No
Loose teeth	☐Yes ☐No	Periodontal treatment	☐Yes ☐No		
Gums swollen/tender	☐Yes ☐No	Sensitive to hot/cold	☐Yes ☐No		

5 – HEALTH HISTORY

Are you required to premedicate with antibiotics prior to dental appointments? ☐Yes ☐No

Has there been a change in your general health within the past year? ☐Yes ☐No

If yes, please explain _____

Have you had any serious illness, operation, or been hospitalized during the past two years? ☐Yes ☐No

Are you now under the care of a physician or health care professional? ☐Yes ☐No

Physician's name _____ Hospital_____ Telephone_____

Are you now taking any medications, drugs or pills? ☐Yes ☐No

If yes, please list: _____

Are you aware of being allergic to or have ever reacted adversely to any medication or substance? ☐Yes ☐No

If yes, please list: _____

Place a mark on "Yes" or "No" to indicate if you have or have had any of the following:

Heart Attack	☐Yes ☐No	Asthma	☐Yes ☐No	AIDS	☐Yes ☐No
Heart Disease	☐Yes ☐No	Emphysema	☐Yes ☐No	HIV Positive	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Heart Surgery	☐Yes ☐No	Sinus Problems	☐Yes ☐No	Drug Addiction	☐Yes ☐No
Heart Pacemaker	☐Yes ☐No	Hay Fever	☐Yes ☐No	Diabetes	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Allergies/Hives	☐Yes ☐No	Anemia	☐Yes ☐No
Chest Pain	☐Yes ☐No	Vision Problems	☐Yes ☐No	Hemophilia	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Glaucoma	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Shortness of breath	☐Yes ☐No	Loss of Hearing	☐Yes ☐No	Blood Transfusion	☐Yes ☐No
Swelling of ankles	☐Yes ☐No	Acid Reflux	☐Yes ☐No	Bruise Easily	☐Yes ☐No
Stroke	☐Yes ☐No	Ulcers	☐Yes ☐No	Jaundice	☐Yes ☐No
Mitral Valve Prolapse	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Epilepsy/Seizures	☐Yes ☐No
Rheumatic Fever	☐Yes ☐No	Thyroid Problems	☐Yes ☐No	Fainting/Dizziness	☐Yes ☐No
Osteoporosis	☐Yes ☐No	Liver Disease	☐Yes ☐No	Nervousness	☐Yes ☐No
Arthritis	☐Yes ☐No	Hepatitis	☐Yes ☐No	Psychiatric Treatment	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Radiation Therapy	☐Yes ☐No	Depression	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Chemotherapy	☐Yes ☐No	Frequent Headaches	☐Yes ☐No
Muscle Pain/Weakness	☐Yes ☐No	Cancer	☐Yes ☐No	Cosmetic Surgery	☐Yes ☐No

(*Females Only:* Are you Pregnant? ☐Yes ☐No Do you take Oral Contraceptives? ☐Yes ☐No **)**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____

6 – CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. And further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to my balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I further understand that failed appointments or cancelled appointments less than 24 hours notice may inquire a charge for the time reserved.

Patient Signature _____

Parent or Responsible Party _____*Relationship to Patient*_____