DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
city state zip

Sex: ____M ____F Age_____ Birthdate_____

Patient SSN:_____

Occupation_____

Employer_____

Employer Address_____

Spouse's Name_____

Birthdate_____SSN_____

Occupation_____

Spouse's employer _____

Employer Phone_____

Whom may we thank for referring you_____

_____

DENTAL INSURANCE

Who is responsible for this account?_____

Relationship to patient_____

Insurance Company_____

Group #_____

Is patient covered by additional insurance? yes no

Subscriber's Name_____

Birthdate_____SSN_____

Relationship to patient_____

Insurance Company_____

Group Number_____

Authorization and Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

_____
Responsible party signature

_____
Relationship Date

PHONE NUMBERS

Home_____Work_____Ext_____E-mail Address_____

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_____

DENTAL HISTORY

Reason for today's visit

_____

Former Dentist_____

City/State_____

Date of Last Dental Visit_____

Date of Last Dental X-rays_____

Mark yes or no to indicate if you have had any of the following:

Bad breath	☐ yes	☐ no
Bleeding gums	☐ yes	☐ no
Blisters on lips or mouth	☐ yes	☐ no
Burning sensation on tongue or lips	☐ yes	☐ no
Chew on one side of of mouth	☐ yes	☐ no
Cigarette, pipe, or other type of smoking	☐ yes	☐ no
Chewing tobacco or dipping	☐ yes	☐ no
Clicking or popping jaw	☐ yes	☐ no
Dry mouth	☐ yes	☐ no
Fingernail biting	☐ yes	☐ no
Food packing between teeth	☐ yes	☐ no
Foreign objects	☐ yes	☐ no
Grinding teeth	☐ yes	☐ no
Gums swollen or tender	☐ yes	☐ no
Jaw pain or tiredness	☐ yes	☐ no
Lip or Cheek biting	☐ yes	☐ no
Loose teeth	☐ yes	☐ no
Broken fillings	☐ yes	☐ no
Mouth breathing	☐ yes	☐ no
Mouth pain, brushing	☐ yes	☐ no
Orthodontic treatment	☐ yes	☐ no
Pain around ear	☐ yes	☐ no
Periodontal treatment	☐ yes	☐ no
Sensitivity to cold	☐ yes	☐ no
Sensitivity to heat	☐ yes	☐ no
Sensitivity to sweets	☐ yes	☐ no
Sensitivity when biting	☐ yes	☐ no
Sores or growths in in mouth	☐ yes	☐ no

How often do you floss?_____
How often do you brush?

HEALTH HISTORY

Aids	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swelling of Feet or Ankles	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor in head or neck	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Do you wear contacts?	☐ Yes ☐ No			Unexplained weight loss	☐ Yes ☐ No

MEDICATIONS

List medications you are currently taking: _____

_____

_____

Physician's Name:_____

Physician's Phone Number: _____

Pharmacy Name: _____

ALLERGIES

☐ Aspirin ☐ Latex

☐ Barbiturates (sleeping pills) ☐ Local Anesthetic

☐ Codeine ☐ Penicillin

☐ Iodine ☐ Sulfa Drugs

Other: _____

_____

SMILE PROFILE

Are you delighted with your smile?_____

Are you pleased with the shape of your smile?_____the color?_____

If you could change anything about your smile what would it be?

_____

_____

Please add anything you feel is important.

_____

_____