REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS # _____

Spouse's Employer _____

Whom may we thank for referring you? _____

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

PHONE NUMBERS

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

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERCENCY, 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 _____

Place a mark on "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	Yes	No
Chew on one side of moutn	Yes	No
Cigarette, pipe, or cigar smoking	Yes	No
Clicking or popping jaw	Yes	No
Dry mouth	Yes	No
Fingernail biting	Yes	No
Food collection between the 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 or broken filings	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 your mouth	Yes	No

How often do you floss? _____

How often do you brush? _____

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, Adioex, Fastin (brand names of phentermine), Poncimin (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
Aftificial 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	Tonsilitis	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

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

ALLERGIES

Aspirin	Local Anesthetic
Barbiturates (Sleeping pills)	Penicillin
Codeine	Sulfa
Iodine	Other _____
Latex	_____

Comments: _____

_____

_____

_____

_____

_____

MEDICATIONS

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

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date