

# DENTAL REGISTRATION AND HISTORY

## 1

### PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

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, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

## 3

### PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-Mail \_\_\_\_\_ Best time to reach you \_\_\_\_\_

#### IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

## 4

### DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken filings <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Check "Yes" or "No" where indicated for all that apply:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like whiter teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
		How often do you brush? _____

# 5

## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

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

- |   |  |                        |  |                                 |  |
|---|--|------------------------|--|---------------------------------|--|
| AIDS  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimers                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis (Type _____) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extraction or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Feet or Ankles      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | Pacemaker              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                 |  |

**WOMEN:** Are you: **Pregnant?**  Yes, \_\_\_\_\_ Months  No **Nursing?**  Yes  No **Taking birth control pills?**  Yes  No

### MEDICATIONS

List medications you are currently taking:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Pharmacy Name \_\_\_\_\_  
 Phone \_\_\_\_\_

### ALLERGIES

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Penicillin  |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Sulfa       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Iodine                        | _____                                |
| <input type="checkbox"/> Latex                         | _____                                |
| <input type="checkbox"/> Local Anesthetic              | _____                                |

**X**

SIGNATURE OF PATIENT OR PARENT OF MINOR

# 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 \_\_\_\_\_