DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

Date ____________________ Email ____ Home Phone __________________________

Cell Phone __________________________

PATIENT INFORMATION

Name ____ Soc. Sec. # ____________________
Last Name First Name Initial

Address ____

City ____ State ________________ Zip ____________________

Sex ☐ M ☐ F Age ________ Birthdate ____________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by ____ Occupation ____________________

Business Address ____ Business Phone ____________________

Spouse or Parents name ____________________________ Employer ____________________ Work # ________________

If Patient is a student, name or school/college ____

Whom may we thank for referring you? ____

In case of emergency who should be notified? ________________________________ Phone ____________________

RESPONSIBLE PARTY

Name of Person Responsible for this Account ________________________________ Relation to Patient ________________

Address ____ Home Phone ____________________

Driver's License # ________________________ Birthdate ____________________ Bank ____________________

Employer ____ Work Phone ____________________

Currently a Patient in our Office? ☐ Yes ☐ No S.S. # ____________________

INSURANCE INFORMATION

Name of Insured ____
Last Name First Name Initial

Relation to Patient ____________________________ Birthdate ________________ Soc. Sec. # ____________________

Address (if different from patient's) ____ Phone ____________________

Person Responsible Employed by ______________________ Occupation ________________ Date Employed ____________

Business Address ____ Business Phone ____________________

Insurance Company ____________________________ Address ____

Contract # ____________________ Group # ____________________ Subscriber # ____________________

How much is your Deductible? ______________ How much have you used? ______________ Max. Annual Benefit ______________

Names of other dependents covered under this plan ____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with ____
Name of Insurance Company(ies)

and assign directly to Dr. ____ all 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 my insurance submissions whether manual or electronic.

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

____________________ ____
Date *Signature of Insured/Guardian*

MINOR / CHILD CONSENT

I, being the parent or guardian of ______________________________ do hereby request
Name of minor/child
and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

______________ ______________________________
Date *Signature of Insured/Guardian*

DENTAL HISTORY

Reason for Today's Visit ______________________________

Former Dentist ______________________________

Address ______________________________

Date of last dental care ______________ Date of last dental X-rays ______________

Check (✓) if you have or had any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Dry Mouth
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? ______________ How often do you brush? ______________

MEDICAL HISTORY

Physician's Name ______________________________ Date of Last Visit ______________

Have you had any serious illnesses or operations? ________ If yes, describe ______________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ______________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe ______________
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Other (not mentioned) ______________
  ____

MEDICATIONS

List medications you are currently taking:

____

____

Pharmacy Name ______________________________

Phone ______________________________

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other ______________
  ____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.
APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

Date ______________ Signature ______________________________