DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential)

DATE:_____

Name_____
First Name Middle Initial Last Name

_____ Sex ☐ M ☐ F Age _____ Birth date _____/_____/_____
Preferred Name or Nickname

Address_____
Street Number or P. O. Box Apt, Bldg or Suite Number etc.

City _____ State_____ Zip_____ Email Address _____
(for appointment confirmation)

Home Phone _____ Cell Phone _____ Work Phone _____

Occupation _____ Marital Status _____ Social Security Number _____

Employer and Business Address_____

In case of Emergency, who should be notified? _____ Relationship_____

Emergency Contact Phone_____ How did you hear about us? ☐ Google ☐ Insurance Company

☐ Postcard ☐ Yellow Pages ☐ Care to Share Card ☐ Friend or Family ☐ Other (please specify):_____

FINANCIAL INFORMATION

Who is responsible for this account? _____ Relationship to Patient_____

Current Street Address_____

City_____State_____Zip_____

Responsible Party Social Security Number _____

INSURANCE INFORMATION

Primary Subscriber's Full Name _____ Birthday _____

Subscriber ID/SSN _____ Relation to Patient_____ Work Phone _____

Insurance Company Name _____ Group Number _____

Insurance Company Address _____

Employer Name & Address _____

For All Patients

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that maybe indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by his office.

Signature of Responsible Party _____ Relationship_____ Date_____

Over →

DENTAL HISTORY

Reason for Today's Dental Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

Address_____

Check (√) if you have had problems with any of the following:

ف Bad Breath
ف Bleeding gums
ف Clicking or popping jaw
ف Food collection between teeth
ف Grinding
ف Loose teeth or broken fillings
ف Periodontal treatment
ف Receding gums
ف Sensitivity to hot/cold
ف Sensitivity to sweets
ف Sensitivity when biting
ف Sores or growths in your mouth

Have you had any injuries to the Mouth/Jaw area? _____

How often do you floss? _____ How often do you brush? _____Do you use soft bristle toothbrush? _____

What kind of toothbrush do you use (regular/manual or electric)? _____

Do you eat a lot of sweets? _____ Do you drink a lot of fruit juices? _____ Do you drink coffee with sugar? _____

Do you drink regular or sugar-free soda? _____ Do you chew regular or sugar-free gum? _____

Please list any problems you would like the Doctor to be aware of _____

Are you happy with the appearance of your teeth? _____ Would you like to change the appearance of your teeth?_____

Do your gums bleed when you brush you teeth? _____

If the patient is a child : is this the first dental visit? _____ Does the child suck their thumb?_____

MEDICAL HISTORY

Name of physician _____ City _____ Date of last physical _____

Please "X" each box if the answer is "Yes", leave blank if "No"

Have you had….

□ Heart Problems
□ High Blood Pressure
□ Low Blood Pressure
□ Circulatory Problems
□ Excessive Bleeding
□ Anemia
□ Hepatitis
□ Diabetes
□ Malignancies
□ Radiation Treatment
□ Epilepsy
□ Kidney Problems
□ Nervous Problems
□ Tuberculosis
□ Cerebral Palsy
□ Scarlet Fever
□ Chronic Sinusitis
□ Chronic Ear Problems
□ Arthritis
□ H.I.V
□ H.T.L.V
□ H.P.V.
□ Herpes
□ Venereal Diseases
□ Asthma
□ C.O.P.D
□ Hip Replacement
□ Knee Replacement

Do you use:
□ Snus
□ Cigars / Pipe
□ Cigarettes
□ Chewing Tobacco
□ E-cigarette
□ Other:_____
***If you use any form of tobacco, how often?** _____

Other Health Complications not listed above: _____

_____

Have you been advised by your doctor to pre-medicate with antibiotics prior to any dental work being performed? _____

Are you allergic to: □ Penicillin □ Codeine □ Local Anesthetics (i.e. Novocaine) □ Other _____

Are you pregnant? _____ If yes how many months?_____

Please list any medications you are taking: _____

_____

Have you ever been hospitalized? _____ If yes please explain _____

_____

Signature of Responsible Party _____ Relationship _____ Date _____