

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 م ف 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding | <input type="checkbox"/> Sensitivity to hot/cold |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Receding gums | <input type="checkbox"/> 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....

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> H.I.V | <u>Do you use:</u> |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> H.T.L.V | <input type="checkbox"/> Snus |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> H.P.V. | <input type="checkbox"/> Cigars / Pipe |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Venereal Diseases | <input type="checkbox"/> Chewing Tobacco |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> E-cigarette |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> C.O.P.D | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Ear Problems | <input type="checkbox"/> Hip Replacement | *If you use any form of tobacco, how often? _____ |
| <input type="checkbox"/> Malignancies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Knee Replacement | |
| <input type="checkbox"/> Radiation Treatment | | | |

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 _____