

DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

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Practice limited to periodontics

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Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial
Address _____ E-mail _____
City _____ State _____ Zip _____
Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone (____) _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (If different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone (____) _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber Name _____ Birthdate _____ Relation to Patient _____
Address (If different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone (____) _____
Insurance Company _____ Soc. Sec. # _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

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 doctor 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

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

DENTAL HEALTH HISTORY

(Confidential)

DENTAL HISTORY

Reason for Today's 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

- | | | |
|--|---|---|
| ☐ Bad breath | ☐ Grinding teeth | ☐ Sensitivity to hot |
| ☐ Bleeding gums | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Clicking or popping jaw | ☐ Periodontal treatment | ☐ Sensitivity when biting |
| ☐ Food collection between teeth | ☐ Sensitivity to cold | ☐ 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 ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. h Yes h No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

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 | ☐ Cortisone Treatments | ☐ Hepatitis | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Cough up Blood | ☐ HIV/AIDS | ☐ Skin Rash |
| ☐ Artificial Joints | ☐ Diabetes | ☐ Jaw Pain | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Kidney Disease | ☐ Swelling of Feet or Ankles |
| ☐ Back Problems | ☐ Fainting | ☐ Liver Disease | ☐ Thyroid Problems |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tobacco Habit |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | ☐ Tonsillitis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Ulcer |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Rheumatic Fever | ☐ Venereal Disease |

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone (____) _____

ALLERGIES

- | | |
|--|--------------------------------------|
| ☐ Aspirin | ☐ Sulfa |
| ☐ Barbiturates (Sleeping pills) | ☐ Latex _____ |
| ☐ Codeine | ☐ Other _____ |
| ☐ Local Anesthetic | _____ |
| ☐ Penicillin | |

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.

Date _____ Signature _____