PATIENT REGISTRATION - HISTORY

Please Print Carefully

Today's Date _____

ADULT 18 & OVER

Patient's Name _____ Nickname _____
Last First Middle

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Birthdate _____ Age ____ Sex _____ Height _____ Weight _____ Race _____ Birthplace _____

Residence: Street _____ City _____ State _____ Zip _____ Phone _____

Employed By: _____ Occupation/Position _____

Business: Street _____ City _____ State _____ Zip _____ Phone _____

Spouse's Name: First, Middle/Maiden, Last _____

Spouse Employed By _____ Occupation/Position _____

Business: Street _____ City _____ State _____ Zip _____ Phone _____

Social Security Numbers: Patient _____ Spouse _____

MINOR 17 & UNDER

Patient's Name _____ Nickname _____
Last First Middle

Birthdate _____ Age ____ Sex _____ Height _____ Weight _____ Race _____ Birthplace _____

Father's Name: First, Middle, Last _____

Mother's Name: First, Middle, Last _____

Residence: Street _____ City _____ State _____ Zip _____ Phone _____

Patient's School _____ Current Grade: _____

Does the patient live with his/her real Father and Mother? _____ If not, please explain the situation. _____

_____

*****IF PATIENT IS MARRIED AND STILL A MINOR PLEASE FILL OUT ADULT SECTION ABOVE*****

What is the reason for your visit today? _____

Who may we thank for referring you to our office? _____

Who should we notify (other than above relative) if an emergency situation arises? _____ Phone _____

If you are filling out this form for someone other than yourself give your name and relationship _____

_____

BILLING

PARTY FINANCIALLY RESPONSIBLE FOR ACCOUNT

(If same as above adult patient or their spouse fill name in only)

Party's Name _____ Nickname _____
Last First Middle

Relationship to above patient _____

Residence: Street _____ City _____ State _____ Zip _____ Phone _____

Employed By: _____ Occupation/Position _____

Business: Street _____ City _____ State _____ Zip _____ Phone _____

Spouse's Name: First, Middle/Maiden, Last _____

Spouse Employed By: _____ Occupation/Position _____

Business: Street _____ City _____ State _____ Zip _____ Phone _____

Social Security Numbers: Responsible Party _____ Spouse _____

THIRD PARTY PARTIAL / FULL COVERAGE

☐ Dental Insurance: 1st Insurance Company/Carrier Name _____

Insurance Company Address _____

Employee/Subscriber Name _____ Social Security No. _____

Group Plan Name _____ Group Plan/Policy No. _____ Local Union No. _____

Spouse's Plan: 2nd Insurance Company Carrier Name _____

Insurance Company Address _____

Employee/Subscriber Name _____ Social Security No. _____

Group Plan Name _____ Group Plan/Policy No. _____ Local Union No. _____

☐ Medicaid/Welfare: Case Name _____ Case No. _____

Patient's suffix No. _____ Patient's Initials _____ Patient's Birthdate _____ Card is Valid to _____

Health/Other Insurance or Benefits covering Dental Services - Explain _____

_____

Note On Your Insurance Coverage

To avoid misunderstandings about insurance coverage, we wish our patients to know that all professional services are charged to and are the responsibility of the patient or responsible party. Your percentage of coverage is a predetermined situation agreed between your employer and your insurance carrier. Our office will prepare necessary information to assist you in obtaining maximum benefits. Please remember to provide completed claim forms for each professional visit. Ask our office secretary for our Dental Insurance handout for further information if you have or will have dental insurance. She will be happy to assist you if you need help.

Acknowledgement And Authority

I give my consent to the Dentist to perform procedures and treatment as necessary or desirable to the care of the patient. Treatment may include, but is not restricted to, administration of medicine, local anesthetics and analgesics; performance of operation; conduct of laboratory; X-rays; or other studies that may be used by the attending Dentist or his qualified staff to correct any oral deficiency, abnormality and/or infection. I also acknowledge full responsibility for payment of such services and agree to pay for them in full, at time of service, unless other arrangements are made with the financial secretary.

Signed _____

Patient, Parent or Agent (must be age 18 or over in order to sign)

Recommended services and fees, will be discussed and financial arrangements completed before beginning treatment. Appointment time is reserved for individuals allowing us to stay on schedule. Please arrive on time for reserved appointments. A minimum charge may be levied for habitual broken/failed appointments without 24 hour advance notice of cancellation. Your information for our records will be considered strictly confidential and we thank you for completing this form as it allows us to better serve your Dental needs.

PATIENT MEDICAL HISTORY

Please Print Carefully

Today's Date _____

Physician _____ Physician's Address _____

Date of Last Medical Exam _____ Reason _____

(Of the following questions please "X" whichever applies to you. Your answers will be held strictly confidential.

1. Are you under any medical treatment now ? ☐
   If yes, please explain _____
2. Are you taking any drugs, medicine, pills or tablets? ☐
   If yes, please explain _____
3. Have you ever had a serious illness, blood transfusion, operation or hospitalization? ☐
   If yes, please explain _____
4. Have you ever had any adverse response to any anesthetics or other drugs (including penicillin)? ☐
   If yes, please explain _____
5. Are you allergic to any known materials resulting in hives, asthma, eczema or skin test? ☐
   If yes, please explain _____
6. Have you ever had a serious accident involving head injuries? ☐
7. Have any wounds healed slowly or presented any other complications? ☐
8. Do you have any problems with prolonged bleeding? ☐
9. Do you have a history of serious headaches, earaches, fainting or seizures? ☐
10. Have you noticed any problems with breathing or unusual swellings? ☐
11. Have you ever had an increase in frequency of urination or thirst? ☐
12. Have you had a recent gain or loss of weight? ☐
13. Have you ever had any radiation or x-ray therapy (other than diagnosis films)? ☐
14. Do you have a tobacco or alcohol habit? ☐
    If yes, please explain _____
15. Has a physician ever told you that you had any:

Please "X" boxes that apply & "✓" appropriate subcategory

☐ Heart or Circulation Problems	☐ Rheumatic Fever	☐ Kidney or Urinary Ailment	☐ Asthma or Hay Fever
☐ Respiratory or Lung Problems	☐ Rheumatism or Arthritis	☐ Venereal Disease	☐ Sinus Problems
☐ Tuberculosis	☐ Diabetes - On Insulin ___ On Diet	☐ Stomach or Intestine Ailment	☐ Stroke, Convulsions, Epilepsy
☐ High Blood Pressure	☐ Jaundice or Liver Ailment	☐ Thyroid or Glandular Disorder	☐ Psychiatric or Emotional Ailment
☐ Low Blood Pressure	☐ Hepatitis - Check Type Below	☐ Tumors, Growths, Cysts	☐ Ear, Eye, Nose, Throat Disorder
☐ Blood Disorder of Anemia	A/Inf ___; B/Serum ___; Unknown	☐ Cancer or Malignancy	☐ Appliances for Preceding

Dentist/Staff Comments (Include Dates) _____

16. Women - Are you pregnant? .... How many months? _____ ☐
17. Have you had any disease, condition or problem not listed above which we should know about? ☐
    If yes, please explain _____
18. Are you in basically good health at this time? ☐

PATIENT DENTAL HISTORY

Date of last dental visit _____ Reason _____

1. Do you have any discomforts, complaints or questions at present? ☐
   If yes, please explain _____

Of the following please "X" appropriate boxes

2. Have you noticed any:
   ☐ Bleeding Gums ☐ Loose Teeth ☐ Food Traps
   ☐ Bad Breath or Taste ☐ Swelling or Lumps in Mouth ☐ Unhealed Mouth Sores
   ☐ Sensitivity to Sweet or Sour ☐ Sensitivity to Hot or Cold ☐ Sensitivity to Pressure
   ☐ Clenching or Grinding ☐ Pain in or around Ears ☐ Jaw Popping, Stiffness, Difficulty
3. Have you had any
   ☐ Extractions ☐ Problems from Extraction ☐ Unfavorable Dental Experience
   ☐ Orthodontic Treatment ☐ Periodontal (Gum) Treatment ☐ Root Canal Therapy
   ☐ Dental Anesthetic ☐ Nitrous Oxide (Laughing Gas) ☐ Problems from Anesthetic or Gas
   ☐ Topical Fluoride Therapy ☐ Brushing or Flossing Instruction ☐ Large Full Mouth X-ray
4. Do you use:
   ☐ Cigarettes, Cigars, Pipe ☐ Chewing Tobacco or Snuff ☐ Chewing Gum (Sugared ___; Non ___)
   ☐ Hard Toothbrush ☐ Medium Toothbrush ☐ Soft Toothbrush
   ☐ Dental Floss or Tape ☐ Toothpicks or Stimulators ☐ Water - Jet Device
   ☐ Fluoridated Water ☐ Fluoride Toothpaste ☐ Fluoride Supplements
5. Do you have any of the following habits?:
   ☐ Finger Sucking ☐ Fingernail Biting ☐ Pencil, Pen, Pipe Chewing ☐ Lip, Tongue, Cheek Chewing
6. Do you have any missing permanent teeth? ☐
   If yes, please explain reason for loss _____
   Have missing teeth been replaced? ☐
   Do you desire replacement? ☐
7. Do you wear any dental appliances (Fixed Bridge, Removable Partial, Full denture)? .... Type Worn _____ ☐
8. Date of last professional cleaning _____ Date of last diagnostic x-ray _____
9. How often do you:
   Have dental check-ups? _____ Have professional Cleanings? _____
   Have diagnostic x-rays? _____ Have topical fluoride? _____
   Brush your teeth? _____ Floss your teeth? _____
10. Are you satisfied with the appearance or condition of your teeth and gums? ☐
    Dentist/Staff Summary _____

PLEASE FEEL FREE TO ASK QUESTIONS AT ANY TIME!