(PLEASE PRINT)

Dental Registration and History

Patient Information

Date _____

ID#/SS# _____

Patient _____

Address _____

_____
City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation _____

Employer _____

Employer Address & Zip _____

Employer Phone (_____) _____

Spouse's Name _____

Birthdate_____SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate_____SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent have insurance coverage with_____ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Phone Numbers

Home (_____)_____ Work (_____)_____ Ext_____ Cell: (_____)_____

E-mail Address _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist_____

City/State_____

Date of last dental visit _____

Date of last dental X-rays _____

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

☐ Bad Breath
☐ Bleeding gums
☐ Blisters on lips or mouth
☐ Burning sensation on tongue
☐ Chew on one side of mouth
☐ Cigarette, pipe, or cigar smoking
☐ Clicking or popping jaw
☐ Dry mouth
☐ Fingernail biting
☐ Food collection between the teeth
☐ Foreign objects
☐ Grinding teeth
☐ Gums swollen or tender
☐ Jaw pain or tiredness
☐ Lip or cheek biting
☐ Loose teeth or broken fillings
☐ Mouth breathing
☐ Mouth pain, brushing
☐ Orthodontic treatment
☐ Pain around ear
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to heat
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in your mouth

How often do you floss?_____

How often do you brush?_____

-OVER-

Health History

Physician's Name _____ Date of last visit _____

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

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

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type_____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the corresponding diagnosis: _____

_____

_____

_____

_____

_____

Pharmacy Name_____ Phone_____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____

ADDITIONAL INFORMATION (OPTIONAL)

Are you happy with the appearance of your teeth / gums / smile? ☐ Yes ☐ No

Would you like to discuss enhancing the appearance of your smile? ☐ Yes ☐ No

What don't you like about your smile? _____

_____

Would you like to discuss how to make your teeth WHITE? ☐ Yes ☐ No