PATIENT REGISTRATION AND MEDICAL/DENTAL HISTORY

ABOUT YOU

Today's Date ____________________________

Name ____ □ Male □ Female

Address ____

Telephone (Home) ____________________ (Work) ______________________ (Cell) __________________________

Date of Birth ___________________ SS# _____________________ Email ____________________________________

Employed by _________________________ Occupation ______________ Driver's Lic. # ________________________

Business Address ____

Status □ Minor □ Single □ Married □ Divorced □ Separated □ Widowed

How did you hear about us? ____

ACCOUNT INFORMATION

PERSON ULTIMATELY RESPONSIBLE FOR THE ACCOUNT

Name ____ Relationship __________________________________

Billing Address ____

Telephone (Home) _____________________ (Work) _______________________ (Cell) ________________________

Date of Birth ___________________ Driver's Lic. # ________________________________ State _______________

Employed by ____________________________ Occupation ____________________ SS# ________________________

Dental Insurance Company ____ Telephone ____________________

Group Number ________________________ ID Number _________________________

IN EVENT OF EMERGENCY

Name ____ Relationship ________________________________

Telephone (Home) ____________________ (Work) ______________________ (Cell) __________________________

MEDICAL HISTORY

Patient's Name ________________________ Today's Date ________________

Physician's Name ________________________ Phone ________________

Date of Last Health Care Exam ________________________________

PLEASE CHECK THE BOX OF ANY CONDITION YOU MAY HAVE HAD

□ AIDS / HIV	□ Back Problems	□ Epilepsy / Seizures	□ Hypoglycemia	□ Rheumatic Fever
□ Allergies to Anesthetics	□ Blood Disease	□ General Allergies * (list below)	□ Kidney Problem	□ Sinus Problem
□ Allergy to Antibiotics	□ Blood Transfusion	□ Glaucoma	□ Low Blood Pressure	□ Special Diet
□ Allergy to Latex	□ Cancer / Leukemia	□ Headaches	□ Mitral Valve Prolapse	□ Stroke
□ Angina Pectoris	□ Chemical Dependency	□ Heart Disease / Attack	□ Nervous Problems	□ Swollen Neck Glands
□ Arthritis / Rheumatism	□ Chemo / Radiation Therapy	□ Heart Murmur	□ Pre-medicate	□ Thyroid Disease
□ Artificial Heart Valves	□ Chronic Diarrhea	□ Heart Pacemaker	□ Psychiatric Care	□ Tuberculosis
□ Artificial Joints	□ Circulatory Problems	□ Hemophilia	□ Recent Weight Loss	□ Ulcer
□ Aspirin Taken Daily	□ Contact Lenses	□ Hepatitis, Jaundice or Liver Disease	□ Respiratory Problem	□ Venereal Disease
□ Asthma	□ Diabetes	□ High Blood Pressure		□ Other * (list below)

*General Allergies ________________________________

*Other ________________________________

Have you ever been advised to be pre-medicated prior to any dental treatment? □ Yes □ No

Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? □ Yes □ No

Have you ever taken any prescription drugs such as Phen-Fen for weight loss? □ Yes □ No

For Women:

	Yes	No		Yes	No		Yes	No
Are You Pregnant?	□	□	Nursing?	□	□	Taking Birth Control Pills?	□	□

Please list any medications you are currently taking and doses:

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________
6. ________________________________
7. ________________________________
8. ________________________________

DENTAL HISTORY

Patient's Name ____ Today's Date ______________________

What is the reason for your visit today? ____

Is there anything about having dental treatment that you would like us to know? □ Yes □ No

If yes, please describe ____

____

Date of Last: **Dental Visit** ________________ **Dental Cleaning** _________________ **X-Ray** ___________________

What treatment was done at your last dental visit? ____

Previous Dentist's Name ________________________________ Telephone ________________________

Do you:	Yes	No
Clench or grind your teeth?	□	□
Mouth breathe while awake or asleep?	□	□
Have tired jaws, especially in the morning?	□	□
Smoke or chew tobacco?	□	□

Any of your teeth sensitive to:	Yes	No
Hot or Cold?	□	□
Sweet?	□	□
Biting or chewing?	□	□

Do your gums bleed easily, feel tender or irritated? □Yes □ No

Are you:	Yes	No
Happy with your smile?	□	□
Pleased with the color of your teeth?	□	□

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners.

I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

____ _____________________________

Signature of Patient or Parent of Minor Date

____ _____________________________

Signature of Staff or Doctor Date