PATIENT REGISTRATION

Patient Name _____ **Sex M ☐ F ☐ Preferred Name/Nickname** _____
Patient's Address _____ **Home Phone** _____
City _____ **State** _____ **Zip Code** _____ **Work Phone** _____
Age _____ **Birthdate** _____ **Cell Phone** _____
☐Single ☐Married ☐Widowed ☐ Separated ☐ Divorced **Email**_____
Patient SS # _____ **Occupation** _____ **Employer** _____
Name of Spouse _____ **Birthdate** _____ **SS#** _____
Occupation _____ **Spouse's Employer** _____
Referred to Office by _____

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IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
Name _____ **Relationship to you** _____
Address and Phone Number of Emergency Contact Person _____

Who is responsible for this account? _____ **Relationship to patient** _____

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Insurance Company _____ **Group #** _____
Is patient covered by additional insurance? ☐yes ☐no Subscriber's name _____
Subscriber's Birthdate _____ **Subscriber's SS#** _____ **Relationship to Patient** _____

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with _____.
I understand that I am financially responsible for all charges whether or not insurance is involved and that any outstanding balances on my account will be my responsibility. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature **Relationship** **Date**

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DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ **City/State** _____
Date of last dental visit _____ **Date of last dental X-rays** _____
Reason for leaving _____
Please check Yes or No to indicate if you have had any of the following:

Bad breath	**☐ Yes ☐ No**	**Bleeding gums**	**☐ Yes ☐ No**	**Blisters on lips or mouth**	**☐ Yes ☐ No**
Burning sensation on tongue	**☐ Yes ☐ No**	**Chew on one side of mouth**	**☐ Yes ☐ No**	**Tobacco Habit**	**☐ Yes ☐ No**
				Fingernail biting	**☐ Yes ☐ No**
Clicking or popping Jaw	**☐ Yes ☐ No**	**Dry mouth**	**☐ Yes ☐ No**	**Grinding teeth**	**☐ Yes ☐ No**
		Food collection between teeth	**☐ Yes ☐ No**	**Orthodontic treatment**	**☐ Yes ☐ No**
Do you or have you ever experienced pain/discomfort in your jaw joint	**☐ Yes ☐ No**			**Gums swollen or tender**	**☐ Yes ☐ No**
		Lip or cheek biting	**☐ Yes ☐ No**	**Sensitivity when biting**	**☐ Yes ☐ No**
		Jaw pain or tiredness	**☐ Yes ☐ No**	**Have you ever had a serious or difficult problem associated with previous dental work**	**☐ Yes ☐ No**
Food collection	**☐ Yes ☐ No**	**Mouth breathing**	**☐ Yes ☐ No**		
Periodontal Treatment	**☐ Yes ☐ No**	**Sensitivity to cold**	**☐ Yes ☐ No**	**Type of bristles**	**☐Hard ☐Medium ☐Soft**
Loose teeth or Broken fillings	**☐ Yes ☐ No**	**Sensitivity to sweets**	**☐ Yes ☐ No**	**Sensitivity to heat**	**☐ Yes ☐ No**
		Sores or growths in your mouth	**☐ Yes ☐ No**		
Pain around ear	**☐ Yes ☐ No**				

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Please check yes or no to indicate if you have had any of the following:

AIDS	□ Yes □ No	**Fainting or dizziness**	□ Yes □ No	**Psychiatric Care**	□ Yes □ No
Alzheimer's	□ Yes □ No	**Glaucoma**	□ Yes □ No	**Radiation Treatment**	□ Yes □ No
Anemia	□ Yes □ No	**Headaches**	□ Yes □ No	**Respiratory problems**	□ Yes □ No
Anxiety	□ Yes □ No	**Head injuries**	□ Yes □ No	**Rheumatic Fever**	□ Yes □ No
Arthritis, Rheumatism	□ Yes □ No	**Heart Murmur**	□ Yes □ No	**Scarlet Fever**	□ Yes □ No
		Heart problems	□ Yes □ No	**Serious accident**	□ Yes □ No
Artificial Heart valves	□ Yes □ No	**Hepatitis Type: _____**	□ Yes □ No	**Shortness of breath**	□ Yes □ No
				Sickle Cell Anemia	□ Yes □ No
Asthma	□ Yes □ No	**Hemophilia**	□ Yes □ No	**Sinus trouble**	□ Yes □ No
Back Problems	□ Yes □ No	**Herpes / Cold Sores**	□ Yes □ No	**Skin rash**	□ Yes □ No
Bleeding abnormally (with extractions or surgery)	□ Yes □ No	**High Blood Pressure**	□ Yes □ No	**Special Diet**	□ Yes □ No
		HIV Positive	□ Yes □ No	**Stroke**	□ Yes □ No
Blood Disease	□ Yes □ No	**Hypoglycemia**	□ Yes □ No	**Swelling of feet / ankles**	□ Yes □ No
Cancer	□ Yes □ No	**Jaundice**	□ Yes □ No	**Swollen neck glands**	□ Yes □ No
Chemotherapy	□ Yes □ No	**Jaw pain**	□ Yes □ No	**Thyroid problems**	□ Yes □ No
Circulatory problems	□ Yes □ No	**Joint Replacement**	□ Yes □ No	**Tonsillitis**	□ Yes □ No
		Kidney Disease	□ Yes □ No	**Tuberculosis**	□ Yes □ No
Congenital Heart Lesions	□ Yes □ No	**Liver Disease**	□ Yes □ No	**Tumor or growth on head or neck**	□ Yes □ No
Cortisone Treatments	□ Yes □ No	**Low Blood Pressure**	□ Yes □ No		
Cough, persistent or bloody	□ Yes □ No	**Mitral Valve Prolapse**	□ Yes □ No	**Ulcer**	□ Yes □ No
		Nervous problems	□ Yes □ No	**Venereal Disease**	□ Yes □ No
Depression	□ Yes □ No	**Pacemaker**	□ Yes □ No	**Any hospital stays?**	□ Yes □ No
Diabetes	□ Yes □ No	**Women:**		**Explain: _____**	
Do you wear Contact lenses?	□ Yes □ No	**Are you Pregnant?**	□ Yes □ No	_____	
		Due Date: _____		_____	
Epilepsy	□ Yes □ No	**Are you nursing?**	□ Yes □ No	_____	
Emphysema	□ Yes □ No	**Are you taking birth control pills?**	□ Yes □ No	_____	

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MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

_____

_____

_____

ALLERGIES

☐ **Amoxicillin**	☐ **Latex**
☐ **Aspirin**	☐ **Local Anesthetic**
☐ **Barbiturates (sleeping pills)**	☐ **Penicillin**
☐ **Codeine**	☐ **Sulfa**
☐ **Erythro**	☐ **Other _____**
☐ **Iodine**	_____

Has your Physician ever advised you to take antibiotics prior to dental appointments? □ Yes □ No

Pharmacy Name _____
Phone _____

I understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____

Patient's Signature **Date**