# Dental Registration and History

## Patient Information

Date_____

Name_____
Last First Middle

Preferred Name/Nickname_____

Address_____

City_____ State_____ Zip _____

**Mailing Address** (if different) _____

_____

Home phone _____Work phone_____

Cell phone_____ Other_____

Birthdate_____ Sex_____ Age_____

Marital Status: Married ☐ Single ☐ Divorced ☐ Other ☐

Email Address_____

## Responsible Party (if other than patient):

Name_____

Relationship to patient _____

Address_____ City _____

State _____Zip _____ Birthdate _____

Home phone_____ Cell phone _____

## Insurance Information

Subscriber Name_____

Employer_____

Birthdate_____ ID/SSN_____

Insurance Co. _____

Group #_____Phone # _____

## Secondary Insurance Information

Subscriber Name _____

Birthdate_____ ID/SSN_____

Insurance Co. _____

Group #_____ Phone #_____

## Who may we thank for referring you?

**Newspaper Ad ☐ Yellow Pages ☐ Drive by ☐**

**Name of person** _____

_____

**Acknowledgement and Release**

I consent to treatment as necessary or desirable to the care the patient first listed above, including but not restricted to drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor or his qualified designate. I also acknowledge and understand that I am financially responsible for all charges whether or not paid by insurance. I also further acknowledge that payment is expected at the time service is rendered unless other arrangements have been made. I authorize the use of my signature on all insurance submissions.

**Signed**_____

**Patient, parent, or responsible party (must be 18 yrs or older)**

## Dental History

Reason for today's visit _____

_____

Former Dentist _____

Date of last visit _____Date of last x-rays _____

Are you happy with your smile? _____

If no, what would you change? _____

_____

How often do you brush? _____

How often do you floss? _____

## Please check if any apply to you

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Dry mouth
- ☐ Grinding teeth
- ☐ Gum swelling
- ☐ Jaw clicks/pops
- ☐ Jaw pain
- ☐ Lip/Cheek biting
- ☐ Tobacco use
- ☐ Loose or broken fillings
- ☐ Orthodontic treatment
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to chewing
- ☐ Sensitivity to sweets
- ☐ Sores/growths in mouth

## Cancellation Policy

We require at least 24 hours notice if you need to cancel or reschedule an appointment. We reserve the right to charge for all broken appointments or short notice changes.

**Signed**_____

# Health History

Medical Doctor's name _____ City/State_____ Phone number_____

When did you last consult your doctor?_____ Reason _____

Have you been a patient in a hospital in the last 5 years? _____ Reason _____

Have you had any serious illnesses or operations?_____

**Please indicate if you have or had any of the following**: If any starred conditions are checked ~ premedication may be required.

| | | | |
|---|---|---|---|
| ☐ Alcoholism | ☐ Cough, Persistent/Bloody | ☐ HIV/AIDS/ARC | ☐ Scarlet Fever |
| ☐ Alzheimers | ☐ Diabetes | ☐ Jaw Pain/TMJ/TMD | ☐ Sinus Trouble |
| ☐ Anemia | ☐ Drug Addiction/Abuse | ☐ Kidney Disease | ☐ Shingles |
| ☐ Arthritis/Rheumatism | ☐ Emphysema | ☐ Leukemia | ☐ Stroke |
| ☐ Artificial Heart Valves* | ☐ Epilepsy | ☐ Liver Disease | ☐ Tattoos |
| ☐ Artificial Joints* | ☐ Fainting | ☐ Mitral Valve Prolapse | ☐ Thyroid Disease |
| ☐ Asthma | ☐ Glaucoma | ☐ Pain in Neck/Back | ☐ Tobacco use |
| ☐ Blood Disease | ☐ Headaches | ☐ Pacemaker* | ☐ Tuberculosis/T.B. |
| ☐ Breathing Problems | ☐ Heart Attack | ☐ Psychiatric Treatment | ☐ Tumor History |
| ☐ Cancer | ☐ Heart Murmur/Defects | ☐ Radiation Treatment | ☐ Ulcer/Stom. Probs. |
| ☐ Chemo Therapy | ☐ Hemophilia | ☐ Renal Dialysis | ☐ Venereal Disease |
| ☐ Chest Pains | ☐ Hepatitis | ☐ Respiratory Disease | ☐ Do you snore? |
| ☐ Circulatory Problems | ☐ High Blood Pressure | ☐ Rheumatic Fever | |

**Any other disease or condition not listed above**:_____

_____

**For Women:** (Please check if applicable) ☐ Pregnant ☐ Nursing ☐ Taking oral contraception (birth control pills)

**Allergies:** (Are you allergic to any of the following) ☐ Acrylic ☐ Iodine ☐ Tylenol ☐ Aspirin ☐ Latex rubber

☐ Metals ☐ Penicillin ☐ Codeine ☐ Local anesthetic ☐ Any Others _____

_____

**Medications:** (Please list any you are currently taking) _____

_____

**** Please indicate if you are taking medications for bone density or osteoporosis****

_____