DENTAL REGISTRATION AND HISTORY

Patient Information

We are please to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glade to help you. We look forward to working with you in maintaining your dental health.

Date_____ Home Phone (_____)_____Cell Phone(_____)_____
Name_____ SS/HIC/Patient ID#_____
Last Name First Name Middle Initial
Address_____ E-mail_____
City_____State_____ Zip_____
Sex M F Age_____ Birthdate_____ Married Widowed Single Minor
Separated Divorced Partnered for_____ years
Patient Employer/School_____ Occupation_____
Employer/School Address_____ Employer/School Phone(_____)_____
Whom may we thank for referring you?_____
In Case of emergency who should be notified?_____ Phone(_____)_____

Primary Insurance

Person Responsible for account_____
Last Name First Name Middle Initial
Relation to Patient_____ Birthdate_____ Id#/Soc.Sec.#_____
Address(If different from patient)_____Phone (_____)_____
City_____ State_____ Zip _____
Person Responsible Employed By_____ Occupation_____
Insurance Company_____ Contract #_____
Group #_____ Subscriber #_____
Names of other dependents covered under this plan_____

Additional Insurance

Is patient covered by additional insurance? Yes No
Subscriber Name_____ Relation to Patient_____ Birthdate_____
Address (If different from patient)_____ _____Phone(_____)_____
City_____ State_____ Zip_____
Subscriber Employed by_____ Business Phone(_____)_____
Insurance Company_____ Soc. Sec.#_____
Contract #_____ Group#_____ Subscriber#_____

Dental History

Reason for Today's Visit_____ Date of last dental care_____
Former Dentist_____ Date of last dental X-rays _____

Check(√) if you have had problem with any of the following:

Bad breath	Grinding teeth	Sensitivity to hot
Bleeding gums	Loose teeth or broken fillings	Sensitivity to sweets
Clicking or popping jaw	Periodontal treatment	Sensitivity to biting

Medical History

Physician's Name_____ Date of Last Visit_____

Have you ever taken any of the group drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you had any serious illnesses or operations? Yes No If yes, describe_____

Have you ever had a blood transfusion Yes No If yes, give approximate dates_____

(Women) Are you Pregnant Yes No Nursing? Yes No Taking birth control pillsYesNo

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

Aids	Cortisone Treatments	Hepatitis	Scarlet Fever
Anemia	Cough, Persistent	High Blood Pressure	Shortness of breath
Arthritis, Rheumatism	Cough up blood	HIV	Skin Rash
Artificial Heart Valves	Diabetes	Jaw Pain	Stroke
Asthma	Epilepsy	Kidney Disease	Swelling of Feet
Back Problems	Fainting	Liver Disease	Thyroid Problems
Blood Disease	Glaucoma	Mitral Valve Prolapse	Tobacco Habit
Cancer	Headaches	Pacemaker	Tonsillitis
Chemical Dependency	Heart Murmur	Radiation Treatment	Tuberculosis
Chemotherapy	Heart Problems	Respiratory Disease	Ulcer
Circulatory Problems	Hemophilia	Rheumatic Fever	Venereal Disease

If there are any changes in your medical history you must notify this office in writing.

MEDICATIONS:
List medications you are currently taking:
_____

ALLERGIES:
Aspirin Barbiturates (sleeping Pills) Codeine Latex
Local Anesthetics Penicillin Sulfa Other_____

Authorization

I certify that I, and/or my dependents(s), have insurance coverage with _____ and assign directly to
Name Of Insurance Company (ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature Of Patient, Parent, Guardian of Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian Or Representative Date