DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATI	ON 9	DENT	'AL INSURANCE	
Date		Who is re-	sponsible for this account?	
SS/HIC/Patient ID #			ient	
Patient NameLast Name				
First Name			by additional insurance? ☐ Yes ☐ No	-
Address	15		• 50000 VOCAS, 100 CONTROL CON	
E-mail				
City			SS#	
StateZip	1.0		ient	
	1 110			
Sex M F Age	Gro	oup #		- ·
Birthdate	1 1 0	SIGNMENT AND F ertify that I, and	RELEASE d/or my dependent(s), have insurance coverage v	vith
Married Widowed Single	∐ Minor		and assign directly	
☐ Separated ☐ Divorced ☐ Partnered f			nsurance Company(ies)	
Patient Employer/School		otherwise payah	all insurance benefits	
Occupation	fina	ncially responsible	for all charges whether or not paid by insurance. I author re on all insurance submissions.	
Employer/School Address			re on all insurance submissions. Intist may use my health care information and may discle	200
	suc	h information to th	e above-named Insurance Company(ies) and their age	nts
Employer/School Phone ()	ben	efits or the benefit	ptaining payment for services and determining insurants payable for related services. This consent will end with	nen
Spouse's Name	my	current treatment	plan is completed or one year from the date signed below	N.
Birthdate		Signature of Pa	atient, Parent, Guardian or Personal Representative	_
SS#				
Spouse's Employer	F	Please print name	of Patient, Parent, Guardian or Personal Representative	
Whom may we thank for referring you?		Date	Relationship to Patient	_
PHONE NUMBERS				
Phone ()			Cell ()	
Spouse's Work () : IN CASE OF EMERGENCY, CONTACT (Specify s				_
Name				
Home Phone ()	Work P	none ()_		_
DENTAL HISTORY				
Reason for today's visit	Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing Yes N	
	Chew on one side of mouth Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Mouth pain, brushing ☐ Yes ☐ N Orthodontic treatment , ☐ Yes ☐ N	
Former Dentist	Clicking or popping jaw	Yes No	Pain around ear Yes N	
City/State	Dry mouth	☐ Yes ☐ No	Periodontal treatment Yes N	
Date of last dental visit	Fingernail biting Food collection between the teeth	☐ Yes ☐ No	Sensitivity to cold Yes N	
Date of last dental X-rays	Foreign objects	☐ Yes ☐ No	Sensitivity to heat Yes N Sensitivity to sweets Yes N	
Place a mark on "yes" or "no" to indicate if you	Grinding teeth	Yes No	Sensitivity when biting	
have had any of the following:	Gums swollen or tender	☐ Yes ☐ No	Sores or growths in your mouth Yes N	0
Bad breath Yes No Bleeding gums Yes No	Jaw pain or tiredness Lip or cheek biting	☐ Yes ☐ No	How often do you floss?	
Blisters on lips or mouth	Loose teeth or broken fillings	Yes No	How often do you brush?	
				-

HEALTH H	IIST	ORY						
						5 1 1/1 1/19		
Physician's Name			THE RESIDENCE OF THE PARTY OF T		atanal Ata	Date of last visit	□ No.	
						Ivia, Didronel, Boniva. Yes	□ No	
names of phentermine), Pond	limin (fen	fluramine)	and Redux (dexfenfluramin	e). 🗌 Yes 🔠		mbinations of Ionimin, Adipex, Fa	astin (bran	a
Place a mark on "yes" or "no"		•	-			Pagniratory Diagona	□ Voc	
AIDS/HIV	Yes	_	Epilepsy	☐ Yes		Respiratory Disease Rheumatic Fever	☐ Yes	
Anemia Arthritia Phaymatiam	☐ Yes		Fainting or dizziness Glaucoma	☐ Yes		Scarlet Fever	☐ Yes	
Arthritis, Rheumatism Artificial Heart Valves	☐ Yes		Headaches	☐ Yes		Shortness of Breath		☐ No
Artificial Joints	Yes	□No	Heart Murmur	☐ Yes	□No	Sinus Trouble		□ No
Asthma	☐ Yes	□No	Heart Problems	☐ Yes	□No	Skin Rash	200	□No
Back Problems	☐ Yes	□No	Hepatitis Type		□No	Special Diet		□No
Bleeding abnormally, with	☐ Yes	□No	Herpes	☐ Yes	□No	Stroke		□No
extractions or surgery			High Blood Pressure	☐ Yes	□No	Swollen Feet or Ankles		□No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	□No	Swollen Neck Glands		□No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	□No	Thyroid Problems		□ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	□No	Tonsillitis	No. of the last of	□ No
Chemotherapy	☐ Yes	□No	Liver Disease	☐ Yes		Tuberculosis	_	□ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	□ No	Tumor or growth on head or	Yes	□ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	□ No	neck		
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	□ No	Ulcer	☐ Yes	
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	*		
Do you wear contact lenses?	☐ Yes	☐ No						
Women:								
Are you pregnant? Yes	☐ No		Due date		Are you nu	rsing? Tes No		
Taking birth control pills?	Yes [] No				,		
MEI	DICA	TIONS	S			ALLERGIES		
List any medications you are currently taking and the correlating		☐ Aspirin ☐ Local Anesthetic						
diagnosis:			□ Barbiturates (Sleeping pills) □ Penicillin					
			☐ Barbiturates (Sleeping pills) ☐ Penicillin					
				☐ Codeine ☐ Sulfa				
Pharmacy Name			Other					
Phone ()			Latex					
Thomas (
UPDATES	(To be	filled in	at future appointmen	nts)				
					2000			
-		1.50	alth since your last dental a					
Are you taking any new medi-	cations?_		If so, what?					
Patient's Signature						Date		
Doctor's Signature						Date•		
Has there been any change in	n your he	alth since	your last dental appointme	nt? Yes	No			
For what conditions?								
Are you taking any new medi	cations?_		If so, what?					
rate you taking any new mean								
						Date		
Patient's Signature						Date		