Dental Registration & History

1 PATIENT INFORMATION

Date: _____

Patient Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Sex: ☐ M ☐ F Age: _____

Birthdate: _____

SS#: _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ___ years

Patient Employer/School: _____

Occupation: _____

Employer/School Address: _____

_____

Employer/School Phone: (___) _____

Spouse's Name: _____

Birthdate: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

_____

_____

2 DENTAL INSURANCE

Who is responsible for this account?: _____

Relationship with Patient: _____

Insurance Co: _____

Group #: _____

Is patient covered by other insurance? ☐ Yes ☐ No

Subscriber's Name: _____

Birthdate: _____ SS #: _____

Relationship with Patient: _____

Insurance Co: _____

Group #: _____

ASSIGNMENT & RELEASE

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of treatment. I understand that my dental insurance is a contract between myself and the insurance carrier, and not between the insurance carrier and the dentist. I understand that I am responsible for all dental charges incurred, regardless of insurance coverage or not. The estimated payment from the insurance company is only an approximation of benefit payment and not a guarantee of payment from your insurance carrier.

I understand and agree to pay any and all collection and/or legal fees incurred, should my account become delinquent. There will be a $50.00 handling fee for any and all returned checks.

I have read the above and fully understand that I am responsible for the total payment of any procedures in this office.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date:

_____

Please print name of Patient, Parent, Guardian or Personal Representative

3 PHONE NUMBERS

Home: (___) _____ Work: (___) _____ ext: _____ Cell: (___) _____

Spouse's Work: (___) _____ Best time and place to reach you: _____

IN CASE OF EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (___) _____ Work Phone: (___) _____

4 DENTAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad Breath	☐ Yes	☐ No	Fingernail biting	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No	Food Collection between teeth	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Foreign objects	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Grinding teeth	☐ Yes	☐ No
Chew on one side of the mouth	☐ Yes	☐ No	Gums swollen or tender	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No			

4 DENTAL HISTORY CONTINUED

CURRENT DENTAL CONCERNS:

Describe your current dental concern: _____ Date of last dental visit: _____

Date of last dental x-ray: _____ Name of previous dentist: _____

REFERRAL:

Why did you choose this office? _____ Are any of your family members patients already? _____

APPREHENSION:

Do you have any fear of having dental treatment done? _____ Anything specific? _____

Have you had any unpleasant dental experiences? _____ Have you ever received laughing gas in a dental office? _____

Have you ever received any other kind of sedation for treatment? _____ Do you feel you need any help overcoming fear? _____

Do you want to be asleep or sedated for your dentistry? _____

YOUR SMILE:

Do you think you have a pretty smile? _____ Are your teeth crooked? _____

If so, does this bother you? _____ Have you ever had any cosmetic dentistry? _____

Do you have any fillings or blemishes on your teeth that you feel look bad? _____

Would you like to have whiter teeth? _____

Is there anything that you feel could make your smile look better? _____

HEADACHES & FACIAL PAIN:

Do you ever have more than one headache a month? _____ Does your jaw ever pop or crack? _____

Do either your jaw or facial muscles ever get tired or sore after chewing, sleeping, stress, etc.? _____

GUM PROBLEMS:

Do your gums ever bleed when you brush or floss? _____ Do your gums drop away from the teeth anywhere? _____

Do you ever have trouble with bad breath or bad taste? _____

TEETH PROBLEMS:

Are your teeth sensitive to hot, cold, sweets, or pressure? _____

Does food regularly wedge between certain teeth? _____ Do you have any areas that are hard to floss? _____

MISSING TEETH:

Do you have any missing teeth? _____ If so, how long? _____

Have they been replaced? _____ Do you have partials or dentures? _____

How long? _____ How old are current ones? _____

Do you have any problem chewing or speaking? _____

Are there any areas of your mouth you can't or don't like to chew on? _____

YOUR DENTAL GOALS:

Health and Function; _____ Cosmetics (looks): _____

Long Term Goals: _____ Other: _____

5 HEALTH HISTORY

Physician's Name: _____ Date of last visit: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bleeding abnormally w/ extractions or surgery	☐ Yes	☐ No	Hepatitis Type	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
			Herpes	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tumor or growth		
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	on neck or head	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	X-Ray Treatment	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No			

WOMEN:

Are you pregnant? ☐ Yes ☐ No Due Date: _____ Are you nursing? _____

Are you taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: _____

_____

Pharmacy Name: _____

Pharmacy Phone: (___) _____

ALLERGIES

☐ Aspirin	☐ Nitrous Oxide	☐ Local Anesthetic
☐ Darvocet	☐ Erythromycin	☐ Penicillin
☐ Codeine	☐ Tetracycline	☐ Novacaine/Xylocaine
☐ Demerol	☐ Percocet	☐ Other (Please Specify)
☐ Latex	☐ Valium	_____

6 UPDATES *(To be filled in at future appointments)*

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? ☐ Yes ☐ No If so, what? _____

_____ _____

Patient's Signature: Date:

_____ _____

Doctor's Signature: Date:

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? ☐ Yes ☐ No If so, what? _____

_____ _____

Patient's Signature: Date:

_____ _____

Doctor's Signature: Date: