DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATI	ON	DE	NTAL INSURANCE	
		S DE	NIAL INSURANCE	
Date		Who	is responsible for this account?	
SS/HIC/Patient ID #	Re	elationship to	Patient	400
Patient NameLast Name	In:	surance Co.		
Last Name	Gi	roup #		
First Name			red by additional insurance? Yes	
Address				
E-mail			ame	
		irthdate	SS#	
City		elationship to	Patient	
State Zip	In:	surance Co.		
Sex \square M \square F Age	Gi	roup #		
Birthdate	AS	SSIGNMENT A	AND RELEASE	
☐ Married ☐ Widowed ☐ Single	☐ Minor	certify that I	, and/or my dependent(s), have insuran	ce coverage with
☐ Separated ☐ Divorced ☐ Partnered	for years	Nam	e of Insurance Company(ies)	assign directly to
Patient Employer/School	an	r ny, otherwise p	all ir payable to me for services rendered. I und	surance benefits, if derstand that I am
Occupation			nsible for all charges whether or not paid by in gnature on all insurance submissions.	surance. I authorize
Employer/School Address			ed dentist may use my health care information	n and may disclose
	su	ich information	to the above-named Insurance Company(ie	s) and their agents
Employer/School Phone ()	be	enefits or the b	of obtaining payment for services and det enefits payable for related services. This cor	sent will end when
Spouse's Name	my	y current treatn	ment plan is completed or one year from the	date signed below.
Birthdate		Cianaturo	of Patient, Parent, Guardian or Personal Rep	proportotivo
SS#		Signature	or Fatient, Fatent, Guardian or Fersonal nep	Dresentative
		Please print n	ame of Patient, Parent, Guardian or Personal	Representative
Spouse's Employer				
Whom may we thank for referring you?		Da	ate Relationship t	o Patient
PHONE NUMBERS				
Phone ()	Work (Ev	t Coll (
Spouse's Work () IN CASE OF EMERGENCY, CONTACT (Specify		The second of th		
Name				
Home Phone ()	Work	Phone (
DENTAL HISTORY				
Reason for today's visit	Burning sensation on tongue	Yes [No Mouth breathing	☐ Yes ☐ No
	Chew on one side of mouth	Yes [No Mouth pain, brushing	☐ Yes ☐ No
Formar Dantiet	Cigarette, pipe, or cigar smoking	g 🗌 Yes 🗀	No Orthodontic treatment	☐ Yes ☐ No
Former Dentist	Clicking or popping jaw		No Pain around ear	☐ Yes ☐ No
City/State	Dry mouth Fingernail biting		No Periodontal treatment No Sensitivity to cold	☐ Yes ☐ No ☐ Yes ☐ No
Date of last dental visit	Food collection between the teeth			☐ Yes ☐ No
Date of last dental X-rays	Foreign objects	Yes		☐ Yes ☐ No
Place a mark on "yes" or "no" to indicate if you	Grinding teeth	☐ Yes ☐		☐ Yes ☐ No
have had any of the following:	Gums swollen or tender	☐ Yes ☐		☐ Yes ☐ No
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		

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Anemia Yes No Fainting or dizziness Yes No Rheumatic Fever Yes Arthritis, Rheumatism Yes No Glaucoma Yes No Scarlet Fever Yes Artificial Heart Valves Yes No Headaches Yes No Shortness of Breath Yes Artificial Joints Yes No Headaches Yes No Shortness of Breath Yes Artificial Joints Yes No Headaches Yes No Shortness of Breath Yes Artificial Joints Yes No Heart Murmur Yes No Shortness of Breath Yes Artificial Joints Yes No Shortness of Breath Yes D Artificial Joints Yes No Shortness of Breath Yes D Deadaches No Shortness of Breath Yes D Deadaches No Shortness of Breath Yes D Deadaches No Skin Rash Yes Deadaches Yes No Skin Rash Yes Deadaches Yes	Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.	Physician's Name		RY						
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenifuramine) and Redux (dexfenfuramine). Yes	Have you ever taken any of the group of 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 No Painting of the following: AlDS/HIV	,						Date of last visit		
Pares of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No	Pares of phentermine), Pondimin (fentfuramine) and Redux (dexfentfuramine). Yes No Painting or dizations Yes	Have you ever used a bisphos	sphonate m	nedication	Common brand names	are Fosamax, A	ctonel, Ate	elvia, Didronel, Boniva. Yes	□ No	
MDS/HIV	MDS/HIV	Have you ever taken any of the	e group of imin (fenflu	drugs coll ramine) a	ectively referred to as "fend Redux (dexfenfluraming	n-phen?" These ne). 🗌 Yes 📗		mbinations of Ionimin, Adipex, F	astin (bran	d
Anemia	Anemia	Place a mark on "yes" or "no"	to indicate	if you hav	e had any of the following	g:				
Arthritis, Rheumatism	Arthritis, Rheumatism	AIDS/HIV	☐ Yes ☐	No	Epilepsy	☐ Yes	□ No	Respiratory Disease	Yes	□ No
Artificial Heart Valves	Artificial Heart Valves Yes No	Anemia	☐ Yes ☐	No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	Yes	□ No
Artificial Joints	Artificial Joints	Arthritis, Rheumatism	Yes [No	Glaucoma	☐ Yes	□ No	Scarlet Fever	Yes	□ N
Sthma	Sthma	artificial Heart Valves	Yes [No	Headaches	☐ Yes	□ No	Shortness of Breath	Yes	□N
Seck Problems Yes No Hepatitis Type Yes No Special Diet Yes New Special Diet Special Diet Yes New Special Diet The Special Diet The Special Diet Yes New Special Diet The Spe	Sack Problems Yes No Hepatitis Type Yes No Special Diet Yes No Special Diet Yes No Special Diet Yes No Special Diet Yes No Special Diet Yes No Special Diet Yes No Special Diet Yes No Stroke Yes No Stroke Yes No Special Diet Yes No Special Diet Yes No Special Diet Yes No Special Diet Yes No No Special Diet Yes No No No Nore Yes No Nore No Nore Nore No Nore Nore	artificial Joints	Yes [No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	Yes	□ N
Bleeding abnormally, with	Bleeding abnormally, with	Asthma	☐ Yes ☐	No	Heart Problems	☐ Yes	□ No	Skin Rash	Yes	□ N
extractions or surgery	extractions or surgery	Back Problems	Yes [No	Hepatitis Type	Yes	□ No	Special Diet	Yes	□ N
Blood Disease Yes No Jaundice Yes No Swollen Neck Glands Yes Cancer Yes No Jaw Pain Yes No Thyroid Problems Yes Cancer Yes No Kidney Disease Yes No Thyroid Problems Yes Chemical Dependency Yes No Kidney Disease Yes No Tonsillitis Yes Chemotherapy Yes No Liver Disease Yes No Tuberculosis Yes Chemotherapy Yes No Low Blood Pressure Yes No Tumor or growth on head or Yes Chemotherapy Yes No Nervous Problems Yes No Nervous Problems Yes No Nervous Problems Yes No Nervous Problems Yes No Ulcer Yes Chemotherapy Yes No Nervous Problems Yes No Venereal Disease Yes No Yes No Pacemaker Yes No Venereal Disease Yes No Yes No Pacemaker Yes No Nervous Problems Yes No Nervo	Slood Disease Yes No Jaundice Yes No Swollen Neck Glands Yes Dancer Yes No Jaw Pain Yes No Thyroid Problems Yes Dancer Yes Dancer Yes No Thyroid Problems Yes Dancer Yes No Thyroid Problems Yes Dancer Yes Dancer Yes No Thyroid Problems Yes Dancer Yes Dancer Yes Dancer Yes No Dancer Yes Dancer Da		☐ Yes ☐] No						□N
Cancer	Cancer		☐ Yes ☐	No						
Chemical Dependency Yes No Kidney Disease Yes No Tonsillitis Yes Chemotherapy Yes No Liver Disease Yes No Tuberculosis Yes No Tuberculosis Yes No Congenital Heart Lesions Yes No Mitral Valve Prolapse Yes No Nervous Problems Yes No Nervous Problems Yes No Ulcer Yes Older Yes Diabetes Yes No Pacemaker Yes No Weight Loss, unexplained Yes No Yes No Nervous Problems Yes No Weight Loss, unexplained Yes No Yes No Nervous Problems Yes No Nervous Problems Yes No Weight Loss, unexplained Yes No No Yes No No No No No No No N	Chemical Dependency Yes No Kidney Disease Yes No Tonsillitis Yes International Dependency Yes No Liver Disease Yes No Tuberculosis Yes International Dependency Yes No Liver Disease Yes No Tuberculosis Yes International Dependency Yes No Liver Disease Yes No Tuberculosis Yes International Dependency Yes No Liver Disease Yes No Tuberculosis Yes International Dependency Yes No Tuberculosis Yes International Dependency Yes No International Dependency Yes No Nervous Problems Yes No Nervous Problems Yes No Ulcer Yes International Dependency Yes No Nervous Problems Yes No Venereal Disease Yes International Problems Yes No Nervous Problems Yes No Weight Loss, unexplained Yes International Problems Yes No Nervous Problems Yes No Weight Loss, unexplained Yes International Problems Yes No Nervous Problems Yes No Nervous Problems Yes No Nervous Problems Yes No Nervous Problems Yes No Weight Loss, unexplained Yes International Problems Yes No Nervous Problems No Nervous Problems Yes No Nervous Problems No Nervous Problems Yes No Nervous Problems Never Yes No Never	Cancer	☐ Yes ☐	No						
Chemotherapy	Chemotherapy	Chemical Dependency	Yes	No						
Correction Yes No Low Blood Pressure Yes No Tumor or growth on head or Yes Congenital Heart Lesions Yes No Mitral Valve Prolapse Yes No neck Nervous Problems Yes No Nervous Problems Yes No Nervous Problems Yes No Ulcer Yes No Nervous Problems Yes No Venereal Disease Yes No Nervous Problems Yes No Nervous Yes No Nervous Problems Yes No Ner	Correction Yes No Low Blood Pressure Yes No Tumor or growth on head or Yes No Nervous Problems Never		☐ Yes ☐	No						
None	Congenital Heart Lesions Yes No Mitral Valve Prolapse Yes No Nervous Problems Yes No Nervous Problems Yes No Nervous Problems Yes No Ulcer Yes Incomplete Yes Incom			No						
No	None South South		☐ Yes ☐	□No					L les	
Cough, persistent or bloody Yes No Pacemaker Yes No Venereal Disease Yes Diabetes Yes No Pacemaker Yes No Weight Loss, unexplained Yes Dementia / Alzheimer Yes No No Nomen: Are you pregnant? Yes No Due date Are you nursing? Yes No ALLERGIES	Cough, persistent or bloody Yes No Pacemaker Yes No Venereal Disease Yes Indians Yes No Pacemaker Yes No Weight Loss, unexplained Yes Indians Yes No No Pacemaker Yes No Weight Loss, unexplained Yes Indians Indian			¬ No					□Yes	\square N
Diabetes Yes No	Diabetes Yes No									
Are you pregnant? Yes No No No No No No No N	Sychiatric Care Sychiatric									
No you wear contact lenses? Yes No No Nomen: Are you pregnant? Yes No No Taking birth control pills? Yes No No Nomen: Are you nursing? Yes No No Nomen None None No No No No No No No N	No you wear contact lenses? Yes No No No No No No No N	imphysema	☐ Yes ☐	□No						
Are you pregnant? Yes	Are you pregnant? Yes		☐ Yes ☐] No	riadiation realinem					
ist any medications you are currently taking and the correlating iagnosis: None	ist any medications you are currently taking and the correlating iagnosis: None				Due date		Are you nu	rsing? 🗌 Yes 🔲 No		
None Barbiturates (Sleeping pills) Penicillin Codeine Sulfa Iodine Other No known allergies	None Barbiturates (Sleeping pills) Penicillin Codeine Sulfa Iodine Other No known allergies	MED	DICAT	IONS				ALLERGIES		
Codeine Sulfa lodine Other Latex No known allergies	□ None □ Codeine □ Sulfa □ Iodine □ Other □ Latex □ No known allergies	liagnosis:			☐ Aspirin ☐ Local Anesthetic					
□ lodine □ Other □ No known allergies	□ lodine □ Other □ No known allergies									
□ Latex □ No known allergies	□ Latex □ No known allergies		_			☐ Codeine		☐ Sulfa		
						□ lodine		Other		
UPDATES	UPDATES	 								
UPDATES	UPDATES					Latex		□ No known	allergies	3
		3 unn arra				Latex		□ No known	allergies	}
		UPDATES				☐ Latex		□ No known	allergies	S
						Latex		□ No known	allergies	5
ist any additional health history information not mentioned above:	ist any additional health history information not mentioned above.		istory info	rmation r	not mentioned above:	Latex		□ No known	allergies	
ist any additional health history information not mentioned above:	ist any additional health history information not mentioned above.		istory info	rmation r	not mentioned above:	Latex		□ No known	allergies	
		ist any additional health hi	·		- - -		YES		allergies	
		ist any additional health hi	·		- - -		YES		allergies	
	Have you been vaccinated for the COVID - 19 virus?	ist any additional health his Have you been vacc	cinated f	for the	- - COVID - 19 virus teding answers and in	s? [□NO		