DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_______________

Name_______________
LAST FIRST MI

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐

Address _______________

____
CITY STATE ZIP

Sex ☐ M ☐ F Birthdate_______________

Patient Employer _______________

Occupation _______________

Employer Address _______________

____

2 DENTAL INSURANCE

Primary Insurance Co._______________

Subscriber's Name _______________

Subscriber's Birthdate _______________

Relationship to Patient_______________

Group # _______________

ID/SS# _______________

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with _______________ and assign directly to Dr._______________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financiallly responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

3 PHONE NUMBERS

Home ( ) _______________ Work ( ) _______________ Ext _______ Cell ( ) _______________

IN CASE OF EMERGENCY, CONTACT:

Name_______________ Relationship_______________ Phone ( ) _______________

4 HEALTH HISTORY

Physician's Name _______________ Phone ( ) _______________

Have you ever taken Fosamax or Actonel for treatment of osteoporosis? ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you had any of the following:

AIDS/HIV	☐ Yes ☐ No	Cortisone Treatments	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	LiverDisease	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Bleeding Abnormalities	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No

ANY OTHER MEDICAL HISTORY THAT WE SHOULD KNOW?

____

WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No How Many Months?_______

Are you nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

MEDICATIONS: List any medications you are currently taking:

____

____

____

ALLERGIES:

☐ Aspirin ☐ Local Anesthesia ☐ Barbiturates

☐ Penicillin ☐ Codeine ☐ Sulfa

☐ Iodine ☐ Latex ☐ Other

5 DENTAL HISTORY

Reason for today's visit_______________

Current Dentist_______________ City/State _______________

The above information is accurate and up to date to the best of my knowledge.

____

Signature (if minor, guardian's signature) Date