DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date___________________________________

SS/HIC/Patient ID#_______________________

Patient Last Name_______________________

First Name_____________________________

Address_______________________________

City, State, Zip_________________________

E-mail _______________________________

Sex ☐M ☐F Age_______

Birthdate___________________________

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered for____ years

Patient Employer/ School__________________

Occupation____________________________

Employer/School Address______________________________

Employer/ School Phone (_____) _______________________

Spouse's Name____

Birthdate____

SS#____

Spouse's Employer ____________________________________

Whom may we thank for referring you?___________________

2 DENTAL INSURANCE

Who is responsible for this account? ______________________

Relationship to patient__________________________________

Insurance Co.____

Group # ____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name_________________________________

Birthdate __________________________SS#________________

Relationship to Patient____________________________________

Insurance Co.____

Group#____

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 financially responsible for all charges 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 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 or Personal Representative

Please print name

Date____ Relationship to Patient

3 PHONE NUMBERS

Home _____________________________ Work ____________________________Cell Phone ___________________________

Spouse's Work _____________________ Best time and place to reach you____

In case of emergency, contact (specify someone who does not live in your household)

Name____Relationship __________________________________

Home Phone _______________________Work _____________________________

4 DENTAL HISTORY

Reason for today's visit ______________

____

General Dentist ______________________

Date of last dental visit _______________

Date of last dental X-rays _______________

Date of last dental cleaning _____________

Have you had any of the following?

Bad breath	☐Yes	☐No
Bleeding gums	☐Yes	☐No
Dry mouth	☐Yes	☐No
Fingernail biting	☐Yes	☐No
Ear pain	☐Yes	☐No
Mouth breathing	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No
Chew on one side of the mouth	☐Yes	☐No
Cigarette, pipe or cigar smoking	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No
Grinding/ clenching of teeth	☐Yes	☐No
Food collection between teeth	☐Yes	☐No
Jaw pain and/or numbness	☐Yes	☐No
Lip or cheek biting	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No

Prior treatment ☐Periodontal ☐Orthodontic

Any ☐Sores ☐Growths ☐Swollen/ tender gums ☐Loose or broken fillings

Sensitivity/pain caused by ☐Cold ☐Heat ☐Sweets ☐Biting ☐Brushing

How often do you brush?____

How often do you floss?____