

DENTAL REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____ ID#/SS# _____
 Patient _____
 Address _____

 City _____ State _____ Zip _____
 Sex: M F Age _____ Birthdate _____
 Single Married Widowed Separated Divorced
 Occupation _____
 Employer _____
 Employer Address _____
 Employer Phone (_____) _____
 Spouse's Name _____
 Birthdate _____ SS# _____
 Occupation _____
 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, the undersigned certify that I (or my dependent) 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

3

PHONE NUMBERS

Home(_____) _____ Work(_____) _____ Ext _____ 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 Phone (_____) _____

4

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

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

Bad breath Yes No

Bleeding gums Yes No

Blisters on lips or mouth Yes No

Burning sensation on tongue Yes No

Chew on one side of mouth Yes No

Cigarette, pipe, or cigar smoking Yes No

Clicking or popping jaw Yes No

Dry mouth Yes No

Fingernail biting Yes No

Food collection between the teeth Yes No

Foreign objects Yes No

Grinding teeth Yes No

Gums swollen or tender Yes No

Jaw pain or tiredness Yes No

Lip or cheek biting Yes No

Loose teeth or broken fillings Yes No

Mouth breathing Yes No

Mouth pain, brushing Yes No

Orthodontic treatment Yes No

Pain around ear Yes No

Periodontal treatment Yes No

Sensitivity to cold Yes No

Sensitivity to heat Yes No

Sensitivity to sweets Yes No

Sensitivity when biting Yes No

Sores or growths in your mouth Yes No

How often do you floss? _____

How often do you brush? _____

Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Date of Birth _____

I. Circle appropriate answer (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
If NO, explain _____
2. Yes / No Has there been a change in your health within the last year?
If YES, explain _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain _____
4. Yes / No Are you being treated by a physician now?
If YES, explain _____
Date of last medical exam? _____ Reason for exam _____
5. Yes / No Have you had problems with prior dental treatment?
If YES, explain _____
Date of last dental exam _____ Name of last treating dentist _____
6. Yes / No Are you in pain now?
If YES, explain _____

II. Have you experienced any of the following? (Please circle Yes or No for each)

- | | | |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina) | Yes / No Blood in stools | Yes / No Frequent vomiting |
| Yes / No Fainting spells | Yes / No Diarrhea or constipation | Yes / No Jaundice |
| Yes / No Recent significant weight loss | Yes / No Frequent urination | Yes / No Dry mouth |
| Yes / No Fever | Yes / No Difficulty urinating | Yes / No Excessive thirst |
| Yes / No Night sweats | Yes / No Ringing in ears | Yes / No Difficulty swallowing |
| Yes / No Persistent cough | Yes / No Headaches | Yes / No Swollen ankles |
| Yes / No Coughing up blood | Yes / No Dizziness | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems | Yes / No Blurred vision | Yes / No Shortness of breath |
| Yes / No Blood in urine | Yes / No Bruise easily | Yes / No Sinus problems |

III. Have you had or do you have any of the following? (Please circle Yes or No for each)

- | | | |
|--|--|-------------------------------------|
| Yes / No Heart disease | Yes / No Cosmetic surgery | Yes / No Eating disorders |
| Yes / No Family history of heart disease | Yes / No Surgeries | Yes / No Osteoporosis |
| Yes / No Heart attack | Yes / No Hospitalization | Yes / No Thyroid disease |
| Yes / No Artificial joint | Yes / No Diabetes | Yes / No Asthma |
| Yes / No Stomach problems or ulcers | Yes / No Family history of diabetes | Yes / No Hepatitis |
| Yes / No Heart defects | Yes / No Tumors or cancer | Yes / No Sexual transmitted disease |
| Yes / No Heart murmurs | Yes / No Chemotherapy | Yes / No Herpes |
| Yes / No Rheumatic fever | Yes / No Radiation | Yes / No Canker or cold sores |
| Yes / No Skin disease | Yes / No Arthritis, rheumatism | Yes / No Anemia |
| Yes / No Hardening of arteries | Yes / No Emphysema or other lung disease | Yes / No Liver disease |
| Yes / No High blood pressure | Yes / No Kidney or bladder disease | Yes / No Eye disease |
| Yes / No Seizures | Yes / No Stroke | Yes / No Transplants |
| | | Yes / No Tuberculosis |

This information will not be released unless specifically authorized by patient.

- Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)

- | | | |
|--|-----------------------|------------------------|
| Yes / No Aspirin | Yes / No Valium | Yes / No Tetracycline |
| Yes / No Darvon | Yes / No Demerol | Yes / No Vicodin |
| Yes / No Codeine | Yes / No Penicillin | Yes / No Percodan |
| Yes / No Latex | Yes / No Food | Yes / No Nitrous oxide |
| Yes / No Local anesthetic
(Novocain or Xylocaine) | Yes / No Erythromycin | Yes / No Metal |

Others _____

V. Are you taking or have you taken any of the following in the last three months? (Please circle Yes or No for each)

- | | | | | | |
|----------|----------------------------|----------|--------------------------|----------|-------------|
| Yes / No | Recreational drugs | Yes / No | Tobacco in any form | Yes / No | Antibiotics |
| Yes / No | Over-the-counter medicines | Yes / No | Alcohol | Yes / No | Supplements |
| Yes / No | Weight loss medications | Yes / No | Bisphosphonate (Fosamax) | Yes / No | Aspirin |
| Yes / No | Cortico - Steroids | | | | |

Please list all medications you are currently taking _____

VI. Women only (Please circle Yes or No for each)

- Yes / No Are you or could you be pregnant? If YES, what month? _____
- Yes / No Are you nursing? _____
- Yes / No Are you taking birth control pills? _____

VII. All patients (Please circle Yes or No for each)

- Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, explain _____
- Yes / No Have you ever been pre-medicated for dental treatment?
If YES, why _____
- Yes / No Have you ever taken Fen-Phen?
If YES, when _____
- Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____ Date _____

Physician's Name _____ Phone Number _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) _____ Date _____ Signature of Dentist _____ Date _____

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT FINANCIAL TERMS

Patient or Responsible Party

Responsible Party: _____ Employment: _____
Address: _____ Address: _____
City: _____ City: _____
Phone: _____ Phone: _____
Parent/Guardian (If Minor) _____

MISSED APPOINTMENTS

No charge will be made for rescheduling an appointment provided 48 hours notice is given. Otherwise a minimum charge of \$25.00 will be incurred. Once an appointment has been made, please remember this time has been reserved specifically for you.

INSURANCE ASSIGNMENTS

If this office is able to accept your insurance company's assignment, it does not absolve the patient of full responsibility for the charges in full for the treatment rendered. The estimate provided by this office is considered as a guideline until the final insurance payment is received and the patient's account has been reconciled. This office can make no guarantee of the insurance payment as estimated. The agreed upon payment plan for the patient's estimated portion must be kept current or the assignment will be canceled and the full amount will become due and payable. Claims are submitted promptly after the treatment is rendered, and if not paid by patient's insurance company by the 61st day after treatment, will be billed in full to the patient. Our administrative staff prides itself on helping our patients maximize their benefits. We are always available to answer your questions.

FINANCIAL CONSENT

The patient (guardian) agrees to be fully responsible for the total payment of procedures performed in this office, including any treatment not a benefit of any insurance the patient may have.

I certify that I have read, understood and agreed to this Patient Financial Policy Agreement.

Patient's Signature _____ Date _____
(Parent/Guardian if patient is a minor)

Date _____
(Doctor's Representative)

Patient's Signature _____ Date _____
(Parent/Guardian if patient is a minor)

Patient's Signature _____ Date _____
(Parent/Guardian if patient is a minor)

Patient's Signature _____ Date _____
(Parent/Guardian if patient is a minor)

Patient's Signature _____ Date _____
(Parent/Guardian if patient is a minor)

Patient's Signature _____ Date _____
(Parent/Guardian if patient is a minor)