

DENTAL REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Whom may we thank for referring you? _____

2

DENTAL INSURANCE

Primary Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

I.D. # _____ Group # _____

Is patient covered by additional insurance? Yes No

Secondary Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

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(ies) 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 of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

3

PHONE NUMBERS

Home (_____) _____

Work (_____) _____

Cell (_____) _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

4

MEDICAL HISTORY

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| <p>List drug allergies: (include adverse reactions) _____</p> <p>_____</p> <p>List medications currently taking: _____</p> <p>_____</p> <p>Are you under the care of a physician? _____</p> <p>If yes, for what? _____</p> <p>_____</p> <p>Mark "yes" or "no" if you have had any of the following:</p> <p>Heart problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Circulatory problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nervous problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Artificial heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis or Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or other _____</p> <p>immunosuppressive disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>General Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinus problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Recent weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen neck glands <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in completion of this form.</p> <p>_____ <small style="margin-left: 100px;">Date</small> <small style="margin-left: 100px;">Patient Signature</small></p> |
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