Dental Registration and History

Patient Information

Date _____

SS/HIC/Patient ID # _____

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

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

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
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

Phone Numbers

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

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	Chew on one side of mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Clicking or popping jaw	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Dry mouth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Lip or cheek biting	☐ Yes	☐ No	How often do you floss? _____		
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____		

Patient Name _____ **Health History** **Date** _____

Medical Doctors Name _____ Date of Last Visit _____

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

AIDS/HIV	☐ YES ☐ NO	Epilepsy	☐ YES ☐ NO	Respiratory Disease	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Fainting or dizziness	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Arthritis, Rheumatism	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Scarlet Fever	☐ YES ☐ NO
Artificial Heart Valves	☐ YES ☐ NO	Headaches	☐ YES ☐ NO	Shortness of Breath	☐ YES ☐ NO
Artificial Joints	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Heart Problems	☐ YES ☐ NO	Skin Rash	☐ YES ☐ NO
Back Problems	☐ YES ☐ NO	Hepatitis Type _____	☐ YES ☐ NO	Special Diet	☐ YES ☐ NO
Bleeding abnormally, with		Herpes	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
extractions or surgery	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Swollen Feet or Ankles	☐ YES ☐ NO
Blood Disease	☐ YES ☐ NO	Jaundice	☐ YES ☐ NO	Swollen Neck Glands	☐ YES ☐ NO
Cancer (Date _____)	☐ YES ☐ NO	Jaw Pain	☐ YES ☐ NO	Thyroid Problems	☐ YES ☐ NO
Chemical Dependency		Kidney Disease	☐ YES ☐ NO	Tonsillitis	☐ YES ☐ NO
Drug Use	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Alcoholism	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO	Tumor or growth on head	
Chemotherapy	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO	or neck	☐ YES ☐ NO
Circulatory Problems	☐ YES ☐ NO	Nervous Problems	☐ YES ☐ NO	Ulcer	☐ YES ☐ NO
Congenital Heart Lesions	☐ YES ☐ NO	Pace Maker	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Cortisone Treatments	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO	Weight Loss, unexplained	☐ YES ☐ NO
Cough persistent or bloody	☐ YES ☐ NO	Radiation Treatment	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO	Do you wear contact lens	☐ YES ☐ NO	Do you have a tattoo	☐ YES ☐ NO
Do you smoke	☐ YES ☐ NO	_____packs per day X _____ years		Do you have a metal allergy	☐ YES ☐ NO

Have you ever had any complications following dental treatment? ☐ YES ☐ NO If yes, please describe _____

Have you ever been hospitalized or do you have any other health concerns? ☐ YES ☐ NO If yes, please describe. _____

_____

MEDICATIONS

List any **medications** you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

_____

List and **herbal medications/alternative medicines** you are currently taking:

_____

_____

List any **'over the counter' medications** you are currently taking:

_____

_____

Have you ever taken any of these medications?

Blood Thinners	☐ YES ☐ NO
Coumadin	☐ YES ☐ NO
Warfarin	☐ YES ☐ NO
Diet Medications	☐ YES ☐ NO
Dexfenfluramine	☐ YES ☐ NO
Fen-Phen	☐ YES ☐ NO
Pondimin	☐ YES ☐ NO
Redux	☐ YES ☐ NO
Levoxyl	☐ YES ☐ NO
Synthroid	☐ YES ☐ NO

ALLERGIES

☐Aspirin ☐Local Anesthetic ☐Barbiturates (Sleeping Pills) ☐Penicillin ☐Codeine

☐Sulfa ☐Iodine ☐Latex ☐ Metals (i.e. gold) ☐Other _____

****

Women:

Are you pregnant ☐ YES ☐ NO Due Date _____

Are you nursing ☐ YES ☐ NO

Are you currently taking an antibiotic? ☐ YES ☐ NO

I have been advised that certain antibiotics and other medications may neutralize the preventative effect of birth control pills, allowing for conception and pregnancy. I understand I need to initiate additional forms of birth control during the period of my treatment and to continue those methods until the next full birth control pill cycle. _____ **(Initial)**

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The information that I have given on the Dental Registration and History form is complete, true and correct to the best of my knowledge. I have fully disclosed my past medical and dental history and have had the opportunity to discuss the treatment and possible problems with my doctor. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that this information will be used by my dentist to help determine appropriate and healthy dental treatment. If there is any change in my medical status, I will inform the dentist. This authorization will end when my current treatment plan is competed or one year from the date signed below. I understand that once the information is released it may be redisclosed by the recipient and may no long be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, Spring Ridge Family Dental Care disclosing the Protected Health Information (PHI). However, if I do revoke this authorization, it will not have any effect on any actions taken by Spring Ridge Family Dental Care disclosing the PHI prior to their receipt of the revocation.

_____ _____

Patient/Guardian signature Date

_____ _____

Doctor's signature Date

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