

PATIENT REGISTRATION AND HEALTH RECORD

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answer that requires clarification or any other information you think I should have. Thank you for your cooperation.

Patient Information (CONFIDENTIAL)

Patient # _____
Soc. Sec. # _____
Date _____
Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
If Patient is a Student, Name of School / College _____ City _____ State _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Social Security # _____ Birthdate _____
Employer _____ Work Phone _____
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	8. Are you allergic to or have you had any reactions to the following?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
			Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use cocaine or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you wearing contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Other (please list) _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have or have you had any of the following?			9. Women Only:		
	Yes	No	a) Are you pregnant or think you may be pregnant? ...	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>			
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>			
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>			
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>			
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>			
11. How do you feel about your smile? _____					
12. About your teeth? _____					
13. Are you interested in whitening your teeth?	<input type="checkbox"/>	Yes			
	<input type="checkbox"/>	No			

Patient Dental History

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any orthodontic work?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Have you ever had instruction on the correct method of brushing your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
a) Clicking?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had instructions on the care of your gums?	<input type="checkbox"/>	<input type="checkbox"/>
b) Pain (joint, ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>			
c) Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>			
d) Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that any balance over 30 days old will be charged a 1.5% finance fee per month, until balance is paid in full. (18% APR). I also understand that should my account have to be referred to any attorney for collection that I am responsible for all fees and cost incurred therein.

Signature _____
(if minor or dependent, parents or guardian's signature)

Date _____