DENTAL REGISTRATION AND HISTORY

	ON	DENT	AL INSURANCE				
Date		Who is resi	oonsible for this account?				
SS/HIC/Patient ID #		Relationship to Patient					
Patient NameLast Name		Insurance Co					
		Group #					
First Name	Middle Initial	Is patient covered by additional insurance? ☐ Yes ☐ No					
Address	s	Subscriber's Name					
E-mail	B	Birthdate	SS#				
City			ent				
State Zip							
Sex M F Age		Group #					
Birthdate		SSIGNMENT AND R	E LEASE or my dependent(s), have insuran	ce coverage wi			
☐ Married ☐ Widowed ☐ Single		certify that i, and					
☐ Separated ☐ Divorced ☐ Partnered for	or years	Name of In	surance Company(ies)	assign directly to			
Patient Employer/School		or.	all in	surance benefits,			
Occupation	a	any, otherwise payable to me for services rendered. I understand that I are financially responsible for all charges whether or not paid by insurance. I authorize					
	th		or all insurance submissions.	surance, raumona			
Employer/School Address		he above-named den	tist may use my health care information	n and may disclos			
			above-named Insurance Company(ie.				
Employer/School Phone ()	b	enefits or the benefits	payable for related services. This con	sent will end whe			
Spouse's Name		iy current treatment p	an is completed or one year from the o	iate signed below			
Birthdate	-	Signature of Par	ient, Parent, Guardian or Personal Rep	presentative			
SS#		Orgination of the					
		Please print name o	f Patient, Parent, Guardian or Personal	D			
Chausa's Employer		i lease print name o	i rationt, rationt, addition of refeeral	Representative			
Spouse's Employer							
Spouse's Employer Whom may we thank for referring you?		Date	Relationship to				
Whom may we thank for referring you?							
Whom may we thank for referring you? PHONE NUMBERS		Date	Relationship to	o Patient			
Whom may we thank for referring you?	Work ()	Date	Relationship to	o Patient			
PHONE NUMBERS Phone () Spouse's Work ()	Work ()	Date Ext	Relationship to	o Patient			
PHONE NUMBERS Phone () Spouse's Work () IN CASE OF EMERGENCY, CONTACT (Specify s	Work () Best time and place to reach you comeone who does not live in you	Date Ext ou our household.)	Relationship to	o Patient			
PHONE NUMBERS Phone () Spouse's Work () N CASE OF EMERGENCY, CONTACT (Specify solution)	Work () Best time and place to reach your comeone who does not live in your means and place to reach your means are the properties.	Ext ou our household.)	Relationship to	o Patient			
PHONE NUMBERS Phone () Spouse's Work () N CASE OF EMERGENCY, CONTACT (Specify solution)	Work () Best time and place to reach your comeone who does not live in your means and place to reach your means are the properties.	Ext ou our household.)	Relationship to	o Patient			
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PHONE NUMBERS Phone () Spouse's Work () N CASE OF EMERGENCY, CONTACT (Specify solution) Home Phone ()	Work () Best time and place to reach your comeone who does not live in your means and place to reach your means are the properties.	Ext ou our household.)	Relationship to	o Patient			
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PHONE NUMBERS Phone () Spouse's Work () N CASE OF EMERGENCY, CONTACT (Specify selected by the content of the cont	Work () Best time and place to reach you comeone who does not live in you Relate Work Burning sensation on tongue Chew on one side of mouth	Ext ou our household.) tionship x Phone () _	Cell () Mouth breathing Mouth pain, brushing	Patient Pes No			
PHONE NUMBERS Phone () Spouse's Work () N CASE OF EMERGENCY, CONTACT (Specify selected by the sel	Work ()	Ext ou our household.) tionship x Phone () Yes	Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment	Patient Yes No Yes No Yes No Yes No			
PHONE NUMBERS Phone () Spouse's Work () N CASE OF EMERGENCY, CONTACT (Specify selection) Name Home Phone () DENTAL HISTORY Reason for today's visit Former Dentist City/State	Work ()	Ext ou our household.) tionship x Phone () Yes	Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold	Patient Yes No Yes No Yes No Yes No Yes No			
PHONE NUMBERS Phone () Spouse's Work () N CASE OF EMERGENCY, CONTACT (Specify selection) Home Phone () DENTAL HISTORY Reason for today's visit Former Dentist City/State Date of last dental visit	Work ()	Ext ou our household.) tionship x Phone () Yes No Yes No Yes No Yes No Yes No Yes No	Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat	Patient Yes No Yes No Yes No Yes No Yes No Yes No			
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PHONE NUMBERS Phone () Spouse's Work () N CASE OF EMERGENCY, CONTACT (Specify selected by the content of the cont	Work ()	Ext ou our household.) tionship x Phone () Yes No Yes No Yes No Yes No Yes No Yes No	Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat	Patient Yes No			
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HEALTH H	IISTOR	Y		~			
D N					Date of look visit		
Physician's Name	sphonate med	ication? Common brand names	are Fosamax Ac	tonel Ate	Date of last visit	П No	
Have you ever taken any of th	e group of dru		n-phen?" These in	nclude co	mbinations of Ionimin, Adipex, F		d
Place a mark on "yes" or "no"	to indicate if y	ou have had any of the followin	g:				
AIDS/HIV	☐ Yes ☐ N	No Epilepsy	☐ Yes	□ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes ☐ N	No Fainting or dizziness	☐ Yes	□ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes ☐ N	lo Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes ☐ N			☐ No	Shortness of Breath		□ No
Artificial Joints	Yes N			□ No	Sinus Trouble		□ No
Asthma	Yes I			□ No	Skin Rash		□ No
Back Problems	☐ Yes ☐ N			□No	Special Diet		□ No
Bleeding abnormally, with extractions or surgery	Yes 1			□ No	Stroke		□ No
Blood Disease	□Yes □N	High Blood Pressure		□ No	Swollen Feet or Ankles		☐ No
Cancer	☐ Yes ☐ N	Jauriuice		□ No □ No	Swollen Neck Glands Thyroid Problems	☐ Yes	□ No
Chemical Dependency	☐ Yes ☐ N	Jaw Falli		□No	Tonsillitis	☐ Yes	□No
Chemotherapy	☐ Yes ☐ N			□No	Tuberculosis		□No
Circulatory Problems	☐ Yes ☐ N			□No	Tumor or growth on head or		□No
Congenital Heart Lesions	☐ Yes ☐ N			□No	neck		
Cortisone Treatments	☐ Yes ☐ N			□No	Ulcer	☐ Yes	□No
Cough, persistent or bloody	☐ Yes ☐ N			□No	Venereal Disease	☐ Yes	□No
Diabetes	☐ Yes ☐ N			□No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes ☐ N			□No			
Do you wear contact lenses? Women:	☐ Yes ☐ N	lo					
Are you pregnant? ☐ Yes Taking birth control pills? ☐	☐ No Yes ☐ No	Due date	A	re you nu	rsing? Yes No		
	1100 1110						
	DICATION	ONS			ALLERGIES		
	DICATIO		☐ Aspirin	s (Sleepin	☐ Local Anesthet	tic	
MED List any medications you are of	DICATIO		☐ Aspirin☐ Barbiturates☐ Codeine	s (Sleepin	☐ Local Anesthet	tic	
MED List any medications you are of diagnosis:	DICATION CONTRACTOR OF THE PROPERTY OF THE PRO	g and the correlating	☐ Barbiturates	s (Sleepin	☐ Local Anesthet		
MED List any medications you are of	DICATION CONTRACTOR OF THE PROPERTY OF THE PRO	g and the correlating	☐ Barbiturates	s (Sleepin	☐ Local Anesthet g pills) ☐ Penicillin ☐ Sulfa ☐ Other		
MEI List any medications you are of diagnosis: Pharmacy Name Phone ()	DICATION CONTRACTOR OF CONTRAC	g and the correlating	Barbiturates Codeine Iodine Latex	s (Sleepin	☐ Local Anesthet g pills) ☐ Penicillin ☐ Sulfa ☐ Other		
MED List any medications you are or diagnosis: Pharmacy Name Phone () UPDATES	DICATION CURRENT CONTRACTOR CONTR	g and the correlating	Barbiturates Codeine Iodine Latex		☐ Local Anesthet g pills) ☐ Penicillin ☐ Sulfa ☐ Other		
MED List any medications you are or diagnosis: Pharmacy Name Phone () UPDATES Has there been any	CTo be filled the change in your	g and the correlating ed in at future appointme	Barbiturates Codeine Iodine Latex	∕es □ l	☐ Local Anesthet g pills) ☐ Penicillin ☐ Sulfa ☐ Other		
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MEI List any medications you are of diagnosis: Pharmacy Name Phone () UPDATES Has there been any For what conditions? Are you taking any new medications.	To be fille change in your cations?	g and the correlating ed in at future appointme ur health since your last dental a	Barbiturates Codeine Iodine Latex nts)	∕es □ l	☐ Local Anesthet g pills) ☐ Penicillin ☐ Sulfa ☐ Other		
MED List any medications you are or diagnosis: Pharmacy Name Phone () UPDATES Has there been any For what conditions? Are you taking any new medication and the second and the s	To be fille change in yo	g and the correlating ed in at future appointme ur health since your last dental a	Barbiturates Codeine lodine Latex nts)	∕es □ l	Local Anesthet g pills) Penicillin Sulfa Other Date Date		
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MED List any medications you are or diagnosis: Pharmacy Name Phone () UPDATES Has there been any For what conditions? Are you taking any new medication and the patient's Signature Doctor's Signature Has there been any change in	To be filled change in your health a	g and the correlating ed in at future appointme ur health since your last dental a If so, what?	Barbiturates Codeine lodine Latex nts) appointment?	∕es □ I	□ Local Anesthet g pills) □ Penicillin □ Sulfa □ Other □ □ No □ Date □ Date		
MED List any medications you are or diagnosis: Pharmacy Name Phone () UPDATES Has there been any For what conditions? Are you taking any new medication and the second and the	To be filled change in your health a	g and the correlating ed in at future appointme ur health since your last dental a If so, what? since your last dental appointme	Barbiturates Codeine lodine Latex nts) appointment?	∕es □ l	□ Local Anesthet g pills) □ Penicillin □ Sulfa □ Other □ □ No □ Date □ Date		
MED List any medications you are or diagnosis: Pharmacy Name Phone () UPDATES Has there been any For what conditions? Are you taking any new medication and the second and the s	To be filled change in your health speations?	g and the correlating ed in at future appointme ur health since your last dental a If so, what? since your last dental appointme	Barbiturates Codeine lodine Latex nts) appointment?	∕es □ l	Local Anesthet g pills) Penicillin Sulfa Other Date Date		