DENTAL REGISTRATION AND HISTORY

PATIENT IN	FORMAT	ION	2 D	ENT	AL INSURANCE	
Date						
SS/HIC/Patient ID #				onsible for this account?		
		Relationship to Patient				
Patient NameLast Name		Insurance Co				
First Name		Middle Initial G	roup #	Harry Co.		<u> </u>
Address	Is	Is patient covered by additional insurance? Yes No			□ No	
	S	Subscriber's Name				
E-mail		В	irthdate _		SS#	
City	R	Relationship to Patient				
State	200	Insurance Co.				
Sex M F Age		Group #				
Birthdate						
☐ Married ☐ Widowed	Single		SSIGNMEN certify tha		or my dependent(s), have insurar	nce coverage with
☐ Separated ☐ Divorced	☐ Partnered	for years			an	d assign directly to
Patient Employer/School			N	lame of Ir	nsurance Company(ies)	
		D	r nv. otherwis	se pavahl	e to me for services rendered. I un	nsurance benefits, if
Occupation			nancially res	ponsible	for all charges whether or not paid by ir	
Employer/School Address			,	3	e on all insurance submissions. tist may use my health care informatic	
Employer/School Phone (fo be m	r the purpo enefits or th y current tre	ose of ob the benefits the eatment p	e above-named Insurance Company(is taining payment for services and de s payable for related services. This co lan is completed or one year from the tient, Parent, Guardian or Personal Re	termining insurance nsent will end when date signed below.
SS#						
Spouse's Employer			Please pri	nt name o	of Patient, Parent, Guardian or Persona	al Representative
Whom may we thank for referring	g you?			Date	Relationship	to Patient
PHONE NUM	MBERS					
·		,			Cell Phone ()	
		Best time and place to reach your someone who does not live in you				
Name			ionship			
Home Phone ()		Work	Phone (_)_		
DENTAL HIS	STORY					
Reason for today's visit		Burning sensation on tongue	☐ Yes	□No	Mouth breathing	☐ Yes ☐ No
		Chew on one side of mouth		□No	Mouth pain, brushing	☐ Yes ☐ No
Former Dentist		Cigarette, pipe, or cigar smokin	g 🗌 Yes	☐ No	Orthodontic treatment	☐ Yes ☐ No
Former Dentist		Clicking or popping jaw	Yes	□ No	Pain around ear	☐ Yes ☐ No
City/State		Dry mouth Fingernail biting	☐ Yes	☐ No	Periodontal treatment Sensitivity to cold	☐ Yes ☐ No ☐ Yes ☐ No
Date of last dental visit		Food collection between the teetl	_	□ No	Sensitivity to heat	☐ Yes ☐ No
Date of last dental X-rays		Foreign objects	Yes	□No	Sensitivity to sweets	☐ Yes ☐ No
Place a mark on "yes" or "no" to	indicate if you	Grinding teeth	☐ Yes		Sensitivity when biting	☐ Yes ☐ No
have had any of the following: Bad breath	☐ Yes ☐ No	Gums swollen or tender	☐ Yes		Sores or growths in your mouth	
Bleeding gums	☐ Yes ☐ No	Jaw pain or tiredness Lip or cheek biting	☐ Yes		How often do you floss?	
Blisters on lips or mouth	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes		How often do you brush?	

HEALTH H	HISTORY						
Bl. ii I N							
Physician's Name	be successful to the second			Date of last visit			
names of phentermine), Pon-	ne group of drugs co dimin (fenfluramine)	ollectively referred to as "fer and Redux (dexfenfluramin	n-phen?″ These include c e).	ombinations of Ionimin, Adipex, Fa	astin (brand		
Place a mark on "yes" or "no"	to indicate if you ha	ve had any of the following	ı:				
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 extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No		
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No		
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Liver Disease Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No		
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse		Tumor or growth on head or neck	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	∐ Yes ∐ No □ Yes □ No	Ulcer	☐ Yes ☐ No		
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No		
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No				
MEDICATIONS			ALLERGIES				
List any medications you are currently taking and the correlating diagnosis:			☐ Aspirin ☐ Local Anesthetic ☐ Barbiturates (Sleeping pills) ☐ Penicillin				
			☐ Barbiturates (Sleepi				
			Codeine	☐ Sulfa			
Pharmacy Name			☐ lodine ☐ Other				
Phone ()			Latex				
I UPDATES	(To be filled in	at future appointmen	ite)				
Has there been any change							
has there been any change	in vour nearin since	vour last dental appointmet	nt? Yes INO				
For what conditions?							
For what conditions?							
Are you taking any new med	lications?	If so, what?					
Are you taking any new med Patient's Signature	lications?	If so, what?		Date			
Are you taking any new med Patient's Signature	lications?	If so, what?		DateDate			
Are you taking any new med Patient's Signature Doctor's Signature	ications?	If so, what?	-	Date			
Are you taking any new med Patient's Signature Doctor's Signature Has there been any change	in your health since	If so, what? your last dental appointmen	nt? □ Yes □ No	Date Date			
Are you taking any new med Patient's Signature Doctor's Signature Has there been any change For what conditions?	in your health since	If so, what? your last dental appointmen	nt? □ Yes □ No	Date Date	••••••		
Are you taking any new med Patient's Signature Doctor's Signature Has there been any change For what conditions?	in your health since	your last dental appointment	nt? □ Yes □ No	Date Date			
Are you taking any new med Patient's Signature Doctor's Signature Has there been any change For what conditions? Are you taking any new med	in your health since	your last dental appointment	nt? □ Yes □ No	DateDate			

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