DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATI	ON 7	DENTA	L INSURANCE	
Date			r this account?	
SS/HIC/Patient ID #			t	
Patient Name				
First Name	Middle Initial			
Address	ls p	patient covered by	additional insurance? Yes	No
E-mail	Sub	bscriber's Name _		
City	Birt	thdate	SS#	
State Zip	Rel	lationship to Patien	t	
	Ins	urance Co		
Sex M F Age	Gro	oup #		54.96
Birthdate		SIGNMENT AND REI		
☐ Married ☐ Widowed ☐ Single	☐ Minor I c	ertify that I, and/or	r my dependent(s), have insurance	
☐ Separated ☐ Divorced ☐ Partnered f	or years	Name of Insu	urance Company(ies) and	assign directly to
Patient Employer/School	Dr	ia and a second	all in	surance benefits, if
Occupation			to me for services rendered. I und r all charges whether or not paid by ins	
Employer/School Address	the	use of my signature of	on all insurance submissions.	
			et may use my health care information above-named Insurance Company(ies	
Employer/School Phone ()	for	the purpose of obta	ining payment for services and detection	ermining insurance
Spouse's Name	man		n is completed or one year from the d	
Birthdate				
SS#		Signature of Patie	ent, Parent, Guardian or Personal Rep	presentative
Spouse's Employer		Please print name of	Patient, Parent, Guardian or Personal	Representative
Whom may we thank for referring you?	- interest ()			
whom may we thank for referring you:		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 s	someone who does not live in your	r household.)		
Name	Relatio	onship		
Home Phone ()	Work P	Phone ()		
<u> </u>				
DENTAL HISTORY				
Reason for today's visit	Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
Trouble today o vicit	Chew on one side of mouth		Mouth pain, brushing	☐ Yes ☐ No
Farman Dankish	Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
Former Dentist	Clicking or popping jaw		Pain around ear	☐ Yes ☐ No
City/State	Dry mouth Fingernail biting		Periodontal treatment Sensitivity to cold	☐ Yes ☐ No
Date of last dental visit	Food collection between the teeth		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		Sensitivity when biting	☐ Yes ☐ No
have had any of the following: Bad breath □ Yes □ No	Gums swollen or tender Jaw pain or tiredness	□ Voc □ No	Sores or growths in your mouth	
Bleeding gums	Lip or cheek biting	☐ Yes ☐ No	How often do you floss?	The second second second
Blisters on lips or mouth ☐ Yes ☐ No	Loose teeth or broken fillings		How often do you brush?	

Physician's Name					Date of last visit					
				clude co	mbinations of Ionimin, Adipex, Fa					
names of phentermine), Pon					momations of forming mapon, ra	our (braire				
Place a mark on "yes" or "no"	" to indicate if you ha	ave 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 ☐	N			
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐	□No	Scarlet Fever	☐ Yes ☐	N			
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐	No	Shortness of Breath	☐ Yes ☐	□ N			
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐] No	Sinus Trouble					
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐		Skin Rash					
Back Problems	☐ Yes ☐ No	Hepatitis Type			Special Diet					
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐		Stroke		_ N			
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐		Swollen Feet or Ankles		_ N			
Cancer	☐ Yes ☐ No	Jaundice		No	Swollen Neck Glands					
Chemical Dependency	☐ Yes ☐ No	Jaw Pain		No	Thyroid Problems					
Chemotherapy	☐ Yes ☐ No	Kidney Disease		No	Tonsillitis					
Circulatory Problems	☐ Yes ☐ No	Liver Disease	Market Street,	No	Tuberculosis					
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐		Tumor or growth on head or neck	☐ Yes ☐] \			
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐	The Late of the La	Ulcer	☐ Yes ☐				
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐		Venereal Disease					
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐		Weight Loss, unexplained	☐ Yes ☐				
Emphysema	☐ Yes ☐ No	Psychiatric Care Radiation Treatment	☐ Yes ☐		Weight 2000, unexplained	_ 100 [
MEDICATIONS						ALLERGIES				
	DICATION	3			ALLERGIES					
List any medications you are			☐ Aspirin		Local Anestheti	ic				
List any medications you are			☐ Aspirin	(Sleepin	☐ Local Anestheti	ic MA				
List any medications you are				(Sleepin	☐ Local Anestheti	ic				
List any medications you are sis: Pharmacy Name	currently taking and	the correlating diagno-	☐ Barbiturates	(Sleepin	☐ Local Anestheti					
List any medications you are sis:	currently taking and	the correlating diagno-	☐ Barbiturates	(Sleepin	☐ Local Anestheti g pills) ☐ Penicillin ☐ Sulfa					
List any medications you are sis: Pharmacy Name Phone ()	currently taking and	the correlating diagno-	☐ Barbiturates ☐ Codeine ☐ Iodine ☐ Latex	(Sleepin	☐ Local Anestheti g pills) ☐ Penicillin ☐ Sulfa					
List any medications you are sis: Pharmacy Name Phone ()	currently taking and	the correlating diagno-	☐ Barbiturates ☐ Codeine ☐ lodine ☐ Latex		☐ Local Anestheti g pills) ☐ Penicillin ☐ Sulfa					
List any medications you are sis: Pharmacy Name Phone () UPDATES Has there been any change	Currently taking and (To be filled in in your health since	at future appointment	Barbiturates Codeine Iodine Latex	do	☐ Local Anestheti g pills) ☐ Penicillin ☐ Sulfa ☐ Other					
List any medications you are sis: Pharmacy Name Phone () UPDATES Has there been any change For what conditions?	(To be filled in in your health since	at future appointment	☐ Barbiturates ☐ Codeine ☐ Iodine ☐ Latex hts) nt? ☐ Yes ☐ N	lo	☐ Local Anestheti g pills) ☐ Penicillin ☐ Sulfa ☐ Other					
List any medications you are sis: Pharmacy Name Phone () UPDATES Has there been any change For what conditions? Are you taking any new medications	Currently taking and (To be filled in in your health since	at future appointment your last dental appointment.	☐ Barbiturates ☐ Codeine ☐ Iodine ☐ Latex hts) nt? ☐ Yes ☐ N	lo	☐ Local Anestheting pills) ☐ Penicillin ☐ Sulfa ☐ Other					
List any medications you are sis: Pharmacy Name Phone () UPDATES Has there been any change For what conditions? Are you taking any new medication.	Currently taking and (To be filled in in your health since	at future appointment your last dental appointment.	☐ Barbiturates ☐ Codeine ☐ Iodine ☐ Latex hts) nt? ☐ Yes ☐ N	Jo	☐ Local Anestheting pills) ☐ Penicillin ☐ Sulfa ☐ Other					
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List any medications you are sis: Pharmacy Name Phone () UPDATES Has there been any change For what conditions? Are you taking any new medication and the signature Doctor's Signature	currently taking and (To be filled in in your health since dications?	at future appointment your last dental appointment of so, what? your last dental appointment of so, what?	☐ Barbiturates ☐ Codeine ☐ Iodine ☐ Latex Ints) Int? ☐ Yes ☐ N	Jo	□ Local Anestheti g pills) □ Penicillin □ Sulfa □ Other □ □ Date □ Date					
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