

PATIENT REGISTRATION

Date _____

Patient Name _____ Date of Birth _____ Male ☐ Female ☐
Last First Middle Initial

Address _____ City _____ State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____ E-Mail _____

Preferred Name _____ Patient's Social Security # _____ Age _____

Spouse/Parents Name _____ Spouse/Parents Employed By _____

DENTAL INSURANCE INFORMATION: PRIMARY:

Employee Name _____ Date of Birth _____ Social Security # _____

Employed by _____ ID/Member # _____ Group # _____

Insurance Co. Name _____ Address _____ City _____

State/Zip _____ Phone # _____

SECONDARY DENTAL INSURANCE INFORMATION:

Employee Name _____ Date of Birth _____ Social Security _____

Employed by _____ ID/Member # _____ Group # _____

Insurance Co. Name _____ Address _____ City _____

State/Zip _____ Phone # _____

Who is responsible for this account? _____ Method of payment: Cash/Check ☐ Credit Card ☐ Insurance ☐

CONSENT:

I consent to diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's) to carry out our treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's) to the following persons who are involved in my care (or my child's) or payment for that care.

My consent to the disclosure of my records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE:

_____ Date _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
- Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No _____
- Are you on a special diet? ☐ Yes ☐ No
- Do you use tobacco? ☐ Yes ☐ No
- Do you use controlled substances? ☐ Yes ☐ No

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

- ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
- ☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Herpes | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | | | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

welcome

PATIENT NUMBER

Patient's Name _____ Last _____ First _____ Initial _____ Nickname _____ Date of Birth _____
Parent's Guardian's Name _____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist?YES NO
2. If not, how long since the last visit to the dentist?
3. Were any x-rays or radiographs taken when your child previously visited the dentist? ...YES NO
4. Does your child eat between meals?YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum?YES NO
6. When does your child brush his/her teeth?
☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before going to bed
7. How does your child receive Fluoride?
☐ Community water level ____ ppm ☐ Well water level ____ ppm
☐ Fluoride drops or tablets ☐ Fluoride rinse or gel
8. Have any cavities been noted in the past?YES NO
9. Does your child suck his/her thumb or fingers?YES NO
10. Were any teeth (baby or permanent) removed by extraction?YES NO
Was it suggested that the space be maintainedYES NO
Was an appliance placedYES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc?YES NO
If so describe
12. Has your child had any problem with dental treatment in the past?YES NO
13. Has anyone in the family, including parents, had orthodontics?YES NO
14. Has your child ever received a local anesthetic?YES NO
15. Has your child ever had occlusal sealants?YES NO
16. Does your child think there is anything wrong with his/her teeth?YES NO

MEDICAL HISTORY

1. Does your child have a health problem?YES NO
2. Is your child under care of physician?YES NO
If yes, since when and why? _____
3. Name of physician _____ Phone _____
4. Is your child receiving any medication?YES NO
What?
5. Is your child allergic to penicillin, antibiotics or other drugs?YES NO
6. Is your child allergic to or sensitive to any metals or latex?YES NO
7. Does your child have other allergies?YES NO
8. Has your child had any serious illness?YES NO
When _____ What
9. Has your child ever had surgery?YES NO
10. Does your child have a heart murmur?YES NO
11. Is surgery contemplated?YES NO
12. Does your child experience severe or prolonged bleeding?YES NO
13. Does your child have AIDS or has he/she tested HIV positive?YES NO
14. Has your child tested positive for hepatitis?YES NO
15. Is your child subject to nervous disorders?YES NO
☐ Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Learning problems?
16. Does your child have frequent headaches?YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

CHILD DENTAL MEDICAL HISTORY