

**PATIENT REGISTRATION AND MEDICAL HISTORY**

(PLEASE PRINT)

Date \_\_\_\_\_

Patient \_\_\_\_\_ S.S. # \_\_\_\_\_  
Last Name First Name Initial Nickname

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell# or other \_\_\_\_\_ Best # to reach you during business hours \_\_\_\_\_

Sex Male Female Drivers License # \_\_\_\_\_ Marital Status: Single – Married – Widowed Date of Birth \_\_\_\_\_  
Please Circle Separated – Divorced - Minor

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_ How Long Held \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_ S.S. # \_\_\_\_\_ Work# ( ) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouses Occupation \_\_\_\_\_ Employed by \_\_\_\_\_ How Long Held \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

In case of an emergency, who should be notified? \_\_\_\_\_ Phone # \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

DENTAL INSURANCE 1<sup>ST</sup> COVERAGE

Employee Name \_\_\_\_\_ Employee Date Of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Insurance Co.Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Group or Policy # \_\_\_\_\_ S.S. # \_\_\_\_\_

DENTAL INSURANCE 2<sup>ND</sup> COVERAGE

Employee Name \_\_\_\_\_ Employee Date Of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Insurance Co.Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Group or Policy # \_\_\_\_\_ S.S. # \_\_\_\_\_

HEALTH INSURANCE COVERAGE

Employee Name \_\_\_\_\_ Employee Date Of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Insurance Co.Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Group or Policy # \_\_\_\_\_ S.S. # \_\_\_\_\_

**RELEASE:**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. **I understand I am financially responsible for payments in full the day of service. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.**

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

Patient's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_ (OVER)

**MEDICAL – DENTAL HISTORY FORM**

Purpose for Initial Visit \_\_\_\_\_

How long since you last dental visit? \_\_\_\_\_

Have you ever responded adversely to medical or dental treatment?  NO  YES, explain \_\_\_\_\_

Have you ever been told to pre-medicate prior to a dental appointment?  NO  YES, explain \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_ Physician Name \_\_\_\_\_ Phone # \_\_\_\_\_

Are you now or have you recently been under a physician's care?  NO  YES, explain: \_\_\_\_\_

Check any of the following that you have had or suspected:

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> High/Low Blood Pressure      |
| <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Sinus Trouble                |
| <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Cancer or Tumor     | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Diabetes                     |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Lung Disease            | <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Kidney/Bladder Trouble       |
| <input type="checkbox"/> Prolonged Bleeding    | <input type="checkbox"/> Fainting Tendency       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Glaucoma                     |
| <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Psychiatric Care        | <input type="checkbox"/> HIV or AIDS         | <input type="checkbox"/> Blood Transfusion   | <input type="checkbox"/> Circulatory Problems         |
| <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Recent Weight Loss  | <input type="checkbox"/> Back Problems       | <input type="checkbox"/> Respiratory Problems         |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Chronic Diarrhea        | <input type="checkbox"/> General Allergies   | <input type="checkbox"/> Special Diet        | <input type="checkbox"/> Swollen Neck Glands          |
| <input type="checkbox"/> Ulcer                 | <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Prosthetic Joint Replacement |

Check any of the following that you are taking or have taken:

- Cortisone Drugs     Anticoagulants     Tranquilizers     Steroids     Blood Thinners     Sedatives

Are you taking any other medication?  NO  Yes, explain: \_\_\_\_\_

Are you taking any herbal supplements such as: **ginger, garlic, feverfew, ginseng or St. John's wort?**  
Please list \_\_\_\_\_

Are you allergic to or do you suffer ill effects from any of the following?

- Penicillin     Dental Anesthesia     Codeine  
 Aspirin     Household Bleach    Any others, please list \_\_\_\_\_

**WOMEN ONLY:** Are you pregnant?  NO  YES, how many months? \_\_\_\_\_ Are you breast feeding?  NO  YES

Are you presently taking any of the following?  Birth Control Pills     Shots     Implants     Hormone Therapy

**CHILD ONLY:**

DENTAL

MEDICAL

Date of last visit to a dentist \_\_\_\_\_  
 For what service? \_\_\_\_\_  
 Has child complained about dental problems?  NO  YES  
 Explain \_\_\_\_\_  
 Any unhappy dental experiences? \_\_\_\_\_  
 Any injuries to mouth – teeth – head?  NO  YES  
 Explain \_\_\_\_\_  
 Any unusual speech habits?  NO  YES  
 Have missing teeth been replaced?  NO  YES  
 Orthodontic appliances ever worn?  NO  YES  
 Does your child brush teeth twice daily?  NO  YES  
 Do you assist child with brushing?  NO  YES  
 How often is dental floss used? \_\_\_\_\_  
 Child's attitude to dentistry \_\_\_\_\_

Is child under care of a physician now?  NO  YES  
 Explain \_\_\_\_\_  
 Is child taking any medication or drugs?  NO  YES  
 Explain \_\_\_\_\_  
 Is there any excessive bleeding when cut?  NO  YES  
 Has child ever been hospitalized?  NO  YES  
 Explain \_\_\_\_\_  
 Is there any allergy to penicillin or other drugs?  NO  YES  
 Explain \_\_\_\_\_  
 Are there other allergies: food – pollen – animals – dust - other?  
 Explain \_\_\_\_\_  
 Does child have good physical coordination?  NO  YES  
 Are there any emotional problems?  NO  YES  
 Explain \_\_\_\_\_

RESPONSIBLE PARTY FOR PATIENT: \_\_\_\_\_ ADDRESS \_\_\_\_\_

The above information is true to the best of my knowledge.

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_