DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Name_____
LAST FIRST MI

Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑

Address _____

_____
CITY STATE ZIP

Sex ❑ M ❑ F Birthdate_____

Patient Employer _____

Occupation _____

Employer Address _____

_____

2 DENTAL INSURANCE

Primary Insurance Co._____

Subscriber's Name _____

Subscriber's Birthdate _____

Relationship to Patient_____

Group # _____

ID/SS# _____

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financiallly responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

3 PHONE NUMBERS

Home ( ) _____Work ( )_____ Ext _____ Cell ( )_____

IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship_____Phone ( )_____

4 HEALTH HISTORY

Physician's Name _____Phone ( ) _____

Have you ever taken Fosamax or Actonel for treatment of osteoporosis? ❑ Yes ❑ No

Place a mark on "yes" or "no" to indicate if you had any of the following:

AIDS/HIV	❑ Yes ❑ No	Cortisone Treatments	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No
Arthritis, Rheumatism	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No
Artificial Heart Valves	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	LiverDisease	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Bleeding Abnormalities	❑ Yes ❑ No	Heart Problems	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No

ANY OTHER MEDICAL HISTORY THAT WE SHOULD KNOW?

_____

WOMEN ONLY: Are you pregnant? ❑ Yes ❑ No How Many Months?_____
Are you nursing? ❑ Yes ❑ No Taking Birth Control Pills? ❑ Yes ❑ No

MEDICATIONS: List any medications you are currently taking:

_____
_____
_____

ALLERGIES:

❑ Aspirin	❑ Local Anesthesia	❑ Barbiturates
❑ Penicillin	❑ Codeine	❑ Sulfa
❑ Iodine	❑ Latex	❑ Other

5 DENTAL HISTORY

Reason for today's visit_____

Current Dentist_____City/State _____

The above information is accurate and up to date to the best of my knowledge.

_____
Signature (if minor, guardian's signature) Date