DENTAL REGISTRY AND HISTORY

PATIENT INFORMATION

Date____

Patient Name ______________________________
Last Name

____
First Name Middle Initial

Address______________________________________

City__________________State_______Zip____________

Sex ☐M ☐F

Birthdate__________ _____ Age______________

☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Patient Employer______________________________

Occupation___________________________________

Patient SS#___________________________________

Spouse's Name________________________________

Phone Numbers (_____)____________(_____)__________
Home# Cell Phone#

(______)______________ _______ ____________________
Work# Ext (Best time to reach you)

Who is responsible for this account?__________________
Print name

Emergency Contact Information

Name________________________Relationship_________

Home Phone (____)________ ___ Work Phone(____)________

____

Who may we thank for referring you?

____

A $25 credit will be applied to your account per each referred family.

ARE YOU HAPPY WITH YOUR SMILE?

Are you happy with your smile?_______

Take a personal smile test:
A= Love it
B= Acceptable
C= Could be better
D= Don't like it
F= Don't like it at all
NP= Not a problem

Comments_______________

____

____

Grade your smile

Whiteness_____________

Staining/discoloration______

Evenness of teeth_________

Chipping or Cracking ______

Existing dental work_______

Gum Health / Appearance___

Smile line _____________

DENTAL INSURANCE

Subscriber's Name_______________________________

Insurance Co.__________________________________

Group#_______________________________________

Relationship to Patient__________________________

Employer______________________________________

Birthdate________________SS#___________________

I certify that I, and /or my dependent(s), have insurance coverage

with ______________and assign directly to Dr. ______________

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please Print Name Date

DENTAL HISTORY

Reason for today's visit___________________________

____

Date of last dental visit___________________________

Date of last dental X-rays_________________________

Please circle to indicate if you have had any of the following:

Bad breath
Bleeding gums
Blisters on lips or mouth
Burning sensation on tongue
Chew on one side of mouth
Clicking or popping jaw
Dry Mouth
Fingernail biting
Food collection between the teeth
Grinding teeth
Gums swollen or tender
Jaw pain or tiredness
Lip or cheek biting
Loose teeth or broken fillings
Mouth breathing
Mouth pain, brushing
Orthodontic treatment
Sores or growth in your mouth

Pain around ear
Periodontal treatment
Sensitivity to cold
Sensitivity to heat
Sensitivity to sweets
Sensitivity when biting

How often do you floss?

____

How often do you brush

____

HEALTH HISTORY

Physician's Name____________________________ **Phone#**______________ **Date of last visit**_______________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combination of Ionimin, Adipex, Fastin (brand names of phentermine), Pondomin (fenfluremine) and Redux (dexfenfluremine). Y/N

Please circle Y/N to indicate if you have had any of the following:

AIDS/HIV	Y/N	Epilepsy	Y/N	Respiratory Disease	Y/N
Anemia	Y/N	Fainting or dizziness	Y/N	Rheumatic Fever	Y/N
Arthritis, Rheumatism	Y/N	Glaucoma	Y/N	Scarlet Fever	Y/N
Artificial Heart Valves	Y/N	Headaches	Y/N	Shortness of Breath	Y/N
Artificial Joints	Y/N	Heart Murmur	Y/N	Sinus Trouble	Y/N
Asthma	Y/N	Heart Problems	Y/N	Skin Rash	Y/N
Back Problems	Y/N	Hepatitis type_____	Y/N	Special Diet	Y/N
Bleeding abnormally, with		Herpes	Y/N	Stroke	Y/N
extractions or surgery	Y/N	High Blood Pressure	Y/N	Swollen Feet or Ankles	Y/N
Blood disease	Y/N	Jaundice	Y/N	Swollen Neck Glands	Y/N
Cancer	Y/N	Jaw Pain	Y/N	Thyroid Problems	Y/N
Chemical Dependency	Y/N	Kidney Disease	Y/N	Tonsillitis	Y/N
Chemotherapy	Y/N	Liver Disease	Y/N	Tuberculosis	Y/N
Circulatory Problems	Y/N	Low Blood Pressure	Y/N	Tumor or growth on head or	Y/N
Congenital Heart Lesions	Y/N	Mitral Valve Prolapse	Y/N	neck	Y/N
Cortisone Treatments	Y/N	Nervous Problems	Y/N	Ulcer	Y/N
Cough, persistent or bloody	Y/N	Pacemaker	Y/N	Venereal Disease	Y/N
Diabetes	Y/N	Psychiatric Care	Y/N	Weight Loss, unexplained	Y/N
Emphysema	Y/N	Radiation Treatment	Y/N	Any history of smoking	Y/N

Do you wear contact lenses? Y/N

Women:

Are you pregnant? Y/N Due date________________ Are you nursing? Y/N
Taking birth control pills? Y/N

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name________________________________

Phone(___)________________________________

ALLERGIES

Y/N Aspirin
Y/N Barbiturates (Sleeping pills)
Y/N Codeine
Y/N Iodine
Y/N Latex
Y/N Local Anesthetic
Y/N Penicillin
Y/N Sulfa

Other____

I affirm that information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Patient's or Parent's Signature ________________________ Date_____ Doctor's Signature __________

MEDICAL HISTORY UPDATES

Date_________ **Comments**____

________________________________ **Signature**____________________ **Signature**__________
(Patient's) (Doctor's)

Date_________ **Comments**____

________________________________ **Signature**____________________ **Signature**__________
(Patient's) (Doctor's)