## **DENTAL REGISTRATION AND HISTORY**

PATIENT INFORMATION	ON	DENT	AL INSURANCE		
Date		no ie responsible f	for this account?		
SS/HIC/Patient ID #			nship to Patient		
Patient Name					
Last Name					
First Name	Middle Initial				
Address	IS		/ additional insurance? ☐ Yes ☐ No		
E-mail	Su				
City	Bir	thdate	SS#		
	Re	lationship to Patie	ent		
State Zip	Ins	urance Co			
Sex M F Age	Gre	oup #			
Birthdate	AS	SIGNMENT AND RI	ELEASE		
☐ Married ☐ Widowed ☐ Single	☐ Minor	ertify that I, and/	or my dependent(s), have insurance coverage with		
☐ Separated ☐ Divorced ☐ Partnered for	years	Name of Ins	surance Company(ies) and assign directly to		
Patient Employer/School	DI.		all insurance benefits, if		
Occupation	any	, otherwise payable	e to me for services rendered. I understand that I am		
Employer/School Address		financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.			
			tist may use my health care information and may disclose a above-named Insurance Company(ies) and their agents		
Employer/School Phone ()	for	the purpose of obt	taining payment for services and determining insurance		
Spouse's Name	mu	current treatment pl	s payable for related services. This consent will end when an is completed or one year from the date signed below.		
Birthdate		Signature of Pat	tient, Parent, Guardian or Personal Representative		
SS#					
Spouse's Employer		Please print name of	f Patient, Parent, Guardian or Personal Representative		
Whom may we thank for referring you?		Date	Relationship to Patient		
S PHONE NUMBERS					
	No. d. (	Fin	Call Phone (		
			Cell Phone ()		
Spouse's Work () E IN CASE OF EMERGENCY, CONTACT (Specify so	Best time and place to reach you				
Name					
Home Phone ()	Work F	hone ()_			
<u> </u>					
DENTAL HISTORY					
Reason for today's visit	Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing ☐ Yes ☐ No		
	Chew on one side of mouth	☐ Yes ☐ No	Mouth pain, brushing Yes No		
F. Daniel D. College	Cigarette, pipe, or cigar smoking Clicking or popping jaw	☐ Yes ☐ No	Orthodontic treatment		
	Dry mouth	☐ Yes ☐ No	Periodontal treatment		
	Fingernail biting	☐ Yes ☐ No	Sensitivity to cold		
	Food collection between the teeth		Sensitivity to heat Yes No		
	Foreign objects Grinding teeth	☐ Yes ☐ No	Sensitivity to sweets Yes No Sensitivity when biting Yes No		
riado a maritor jos er no to marouro mjeu	Gums swollen or tender	☐ Yes ☐ No	Sores or growths in your mouth Yes No		
	Jaw pain or tiredness	☐ Yes ☐ No	How often do you floss?		
	Lip or cheek biting	☐ Yes ☐ No			
Blisters on lips or mouth ☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No	How often do you brush?		

HEALTH H	1151 OKY				
Physician's Name				Date of last visit	
	he group of drugs co	ellectively referred to as "fer	n-phen?" These include	de combinations of Ionimin, Adipex, F	astin (brand
names of phentermine), Pond					
Place a mark on "yes" or "no'	to indicate if you ha	ive had any of the following			
AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ N	o Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ N	o Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ N		Yes No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ N		☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ N		☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ N		☐ Yes ☐ N
Back Problems	☐ Yes ☐ No	Hepatitis Type	Yes N		☐ Yes ☐ N
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes High Blood Pressure	☐ Yes ☐ N		☐ Yes ☐ N
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ N		☐ Yes ☐ N
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ N		☐ Yes ☐ N
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ N		☐ Yes ☐ N
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ N		☐ Yes ☐ N
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ N		☐ Yes ☐ N
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ N		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ N	10	☐ Yes ☐ N
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ N		☐ Yes ☐ N
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ N	o Weight Loss, unexplained	☐ Yes ☐ N
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ N	0 0	
MEDICATIONS		ALLERGIES			
List any medications you are currently taking and the correlating diagnosis:		☐ Aspirin	☐ Local Anesthe	tic	
		☐ Barbiturates (Sle	eeping pills)	☐ Penicillin	
			☐ Codeine ☐ Sulfa		
Pharmacy Name			☐ lodine	Other	
Phone ()					
UPDATES	(To be filled in	at future appointmen	nts)		
		at future appointmen			
Has there been any change	in your health since	your last dental appointme	nt? 🗌 Yes 🔲 No		
Has there been any change For what conditions?	in your health since	your last dental appointme	nt? 🗌 Yes 🔲 No		
Has there been any change For what conditions?  Are you taking any new med	in your health since	your last dental appointme	nt?  Yes  No		
Has there been any change For what conditions?  Are you taking any new med Patient's Signature	in your health since	your last dental appointme	nt?  Yes  No	Date	
Has there been any change For what conditions? Are you taking any new med Patient's Signature Doctor's Signature	in your health since	your last dental appointme	nt?  Yes  No	Date	
Has there been any change For what conditions? Are you taking any new med Patient's Signature Doctor's Signature	in your health since	your last dental appointme	nt?  Yes  No	Date	
Has there been any change For what conditions? Are you taking any new med Patient's Signature Doctor's Signature Has there been any change	in your health since	your last dental appointme  If so, what? your last dental appointme	nt?	DateDate	
Has there been any change For what conditions? Are you taking any new med Patient's Signature  Doctor's Signature  Has there been any change For what conditions?	in your health since	your last dental appointme If so, what? your last dental appointme	nt?	DateDate	
Has there been any change For what conditions? Are you taking any new med Patient's Signature Doctor's Signature Has there been any change For what conditions?	in your health since	your last dental appointme If so, what? your last dental appointme If so, what?	nt?	DateDate	