

# DENTAL REGISTRATION AND HISTORY

## 1

### PATIENT INFORMATION

Date \_\_\_\_\_  
Patient \_\_\_\_\_  
How do you wish to be addressed \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Single  Married  Widowed  Separated  Divorced  
Patient SS# \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Phone \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Occupation \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## 2

### DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_  
Is patient covered by additional insurance?  Yes  No  
Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_

#### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) 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 financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

## 3

### CONTACT INFORMATION

Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Spouse's Work \_\_\_\_\_  
Best time and place to reach you \_\_\_\_\_ Email \_\_\_\_\_  
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## 4

### FINANCIAL / CANCELLATION POLICY

**Payment for services** is expected at the time service is provided. If an extended payment plan is desired, please let us know before treatment begins.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added. To make sure that every patient gets individual attention, we set aside dedicated time for each appointment. **Cancellation Policy** If you find it necessary to cancel an appointment, we request that you provide the dental office with 24 hours notice. If appropriate notice is not given, you may be charged \$50 for a broken or cancelled appointment. This fee is subject to change without notice.

#### If you have dental insurance...

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have questions about "UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

Signature \_\_\_\_\_

# 5 HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's and/or Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date _____	
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Abnormally with		HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extractions or Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor /Growth on Head/Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, Persistent or		Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women: Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unlisted Medical Condition _____	
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No				

# 6 MEDICATIONS

List medications you are currently taking: \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone \_\_\_\_\_

# ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Barbiturates (Sleeping Pills)
<input type="checkbox"/> Codeine	<input type="checkbox"/> Iodine
<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Other _____	

# 7 DENTAL HISTORY

Reason for Today's Visit: \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of Last Visit \_\_\_\_\_ Date of Last X-ray \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Please mark on "Yes" or "No" to indicate if you have had any of the following:	Fingernail Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food Collection Between the Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Around Ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign Objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips/mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Sensation on Tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums Swollen or Tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on One Side of Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain or Tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe, or Cigar Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or Cheek Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or Popping Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose Teeth or Broken Fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores/Growths in Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
		Mouth Pain, Brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____	

# 8 ANALYZE YOUR OWN SMILE

If you answered yes to any of these please discuss your options with us.

Do you have any concerns about your smile?	Are some of your teeth darker than the others?
Do some of your teeth have white or brown stains?	Would you like a white more youthful smile?
Do you see any defect in the appearance of your teeth or gums?	Are there spaces or gaps between any of your teeth?
Are any of your teeth crooked, jagged, worn or chipped?	Do you have missing teeth that you would like replaced?
Is the appearance of your smile out of balance from one side to the other?	Are any of your teeth too long or too short?
Is there anything else you would like to change about your teeth or smile?	Are your teeth crowded? If so, are they getting worse?
Are you self-conscious or do you cover your mouth with your hand when you smile or talk?	
Do you have old fillings, bonding, veneers or crowns that are chipped, discolored misshaped worn or otherwise in need up upgrading?	