DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date

SS/HIC/Patient ID #

Patient Name

Last Name

First Name Middle Initial

Address

Email

City

State Zip

Sex ☐ M ☐ F Age

Birthdate

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ____ years

Patient Employer/School

Occupation

Employer/School Address

Employer/School Phone ( )

Spouse's Name

Birthdate

SS#

Spouse's Employer

Whom may we thank for referring you?

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.

Group #

ASSIGNMENT AND RELEASE

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

and assign directly to

Name of Insurance Company(ies)

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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

PHONE NUMBERS

Phone ( ) Work ( ) Ext Cell ( )

Spouse's Work ( ) Best time and place to reach you

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name Relationship to Patient

Home Phone ( ) Work Phone ( )

DENTAL HISTORY

Reason for today's visit

Former Dentist

City/State

Date of last dental visit

Date of last dental X-rays

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

Bad breath	Yes ☐	No ☐
Bleeding gums	Yes ☐	No ☐
Blister on lips or mouth	Yes ☐	No ☐
Burning sensation on tongue	Yes ☐	No ☐
Chew on one side of mouth	Yes ☐	No ☐
Cigarette, pipe, or cigar smoking	Yes ☐	No ☐
Clicking or popping jaw	Yes ☐	No ☐
Dry mouth	Yes ☐	No ☐
Fingernail biting	Yes ☐	No ☐
Food collection between the teeth	Yes ☐	No ☐
Foreign objects	Yes ☐	No ☐
Grinding teeth	Yes ☐	No ☐
Gums swollen or tender	Yes ☐	No ☐
Jaw pain or tiredness	Yes ☐	No ☐
Lip or check biting	Yes ☐	No ☐
Loose teeth or broken fillings	Yes ☐	No ☐
Mouth breathing	Yes ☐	No ☐
Mouth pain, brushing	Yes ☐	No ☐
Orthodontic treatment	Yes ☐	No ☐
Pain around ear	Yes ☐	No ☐
Periodontal Treatment	Yes ☐	No ☐
Sensitivity to cold	Yes ☐	No ☐
Sensitivity to heat	Yes ☐	No ☐
Sensitivity to sweets	Yes ☐	No ☐
Sensitivity when biting	Yes ☐	No ☐
Sores or growths in your mouth	Yes ☐	No ☐

How often do you floss?

How often do you brush?

Submit