## **DENTAL REGISTRATION AND HISTORY**

PATIENT IN	FORMAT	ION	DENT	AL INSURANCE	
Date			Vho is responsible	for this account?	
SS/HIC/Patient ID #				ent	
Patient Name					
Patient NameLast Name			Broup #		
First Name		Middle Initial			
Address				y additional insurance? Yes	No
E-mail			Subscriber's Name		
City				SS#	
		F	Relationship to Pation	ent	
State			nsurance Co		
Sex M F Age			Group #		
Birthdate			ASSIGNMENT AND R	ELEASE	
☐ Married ☐ Widowed	☐ Single	☐ Minor	certify that I, and	or my dependent(s), have insurar	nce coverage with
☐ Separated ☐ Divorced	☐ Partnered	for years	Name of In	surance Company(les)	d assign directly to
Patient Employer/School			Or.		nsurance benefits, i
Occupation		8	ny, otherwise payabl	e to me for services rendered. I un	derstand that I an
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.		
- Employer/Scribol Address		7		itist may use my health care information	
				e above-named insurance Company(le	
Employer/School Phone (		b	enefits or the benefits	s payable for related services. This con lan is completed or one year from the	nsent will end when
Spouse's Name			ny carrent treatment p	nam is completed of one year from the	date signed below.
Birthdate		<u> </u>	Signature of Pa	tient, Parent, Guardian or Personal Re	presentative
SS#			Oignature of Fa	mont, ratorit, obalidati or i oroonal no	prodonitativo
Spouse's Employer	Section 2		Please print name of	of Patient, Parent, Guardian or Persona	I Representative
Whom may we thank for referr	ing you?	10		100	
			Date	Relationship t	o Patient
3 PHONE NU	MDEDC				
PHONE NO	MBERS				
Home ()		Work ()	Ext	Cell Phone ()	
		Best time and place to reach y			
		someone who does not live in yo			
Name		Rela	tionship		
Home Phone ()		Work	(Phone ()_		10000
<u> </u>					
DENTAL H	ISTORY				
-		D		Mouth breathing	□Vac □Na
Reason for today's visit		Burning sensation on tongue Chew on one side of mouth	☐ Yes ☐ No	Mouth breathing  Mouth pain, brushing	☐ Yes ☐ No
		Cigarette, pipe, or cigar smoking		Orthodontic treatment	☐ Yes ☐ No
Former Dentist		Clicking or popping jaw	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
City/State		Dry mouth	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Date of last dental visit		Fingernail biting	Yes No	Sensitivity to cold	☐ Yes ☐ No
Date of last dental X-rays		Food collection between the tee Foreign objects		Sensitivity to heat Sensitivity to sweets	☐ Yes ☐ No
Place a mark on "yes" or "no"		Grinding teeth	☐ Yes ☐ No	Sensitivity when biting	Yes No
have had any of the following:		Gums swollen or tender	Yes No	Sores or growths in your mouth	
Bad breath	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No	How often do you floss?	
Bleeding gums	☐ Yes ☐ No	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?	

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).	Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adi names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). $\square$ Yes $\square$ No	
hannes of phentermino). Production (ferifuramino) and Rodux (dexefinfuramino).   Yes   No   Paleae a mark on "yes" or "no" to indicate it you have had any of the following:    AlpSAIP	names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).   Yes   No	
AlbS/HV	Place a mark on "yes" or "no" to indicate if you have had any of the following:	bex, Fastin (brand
Anomia   Ves   No   Fainting or dizziness   Ves   No   Rheumatic Fever   No   Rheumatic Fever   No   Rheumatic Fever   Rheumatic		
Anemia		□ Yes □
Arthritis   Rheumatism		
Artificial Joints		
Artificial Joints		
Asthma		
Bleeding abnormality, with	Asthma ☐ Yes ☐ No Heart Problems ☐ Yes ☐ No Skin Rash	☐ Yes ☐
extractions or surgery	Back Problems	☐ Yes ☐
Slood Disease	autorations as autoras.	
Cancer	Pland Diseases	
Chemical Dependency   Yes   No   Kloney Disease   Yes   No   Tonsillitis   Yes   No   Tonsillitis   Yes   No   Yes   Yes   Yes   No   Yes	Jauridice Tes No Swollen Neck Glands	Control of the Control of the Control
Chemotherapy   Yes   No   Liver Disease   Yes   No   Tuberculosis   Yes   No   Compositive Problems   Yes   No   Compositive Problems   Yes   No   No   No   No   No   No   No   N	Chemical Department   Jaw Falli   Tes   No Trigiou Flobletts	
Circulatory Pgoblems	Chamatharany No. 7 No. 7 No.	
Congenital Heart Lesions   Yes   No   Mitral Valve Prolapse   Yes   No   Norvous Prolapse   Yes   No   Yes   Yes	Circulators Dyshlama	
Cortisone Treatments	Constraint Heart Legisland West Table	ad or Yes
Cough, persistent or bloody   Yes   No   Pacemaker   Yes   No   Venereal Disease   Yes   No   Pacemaker   Yes   No   Venereal Disease   Yes   No   Pacemaker   Yes   No   Venereal Disease   Yes   No   Pacemaker   Yes   No   No   No   Yes   No   No   No   No   No   No   No   N	Costinono Trastmento	□ Ves □
Diabetes   Yes   No   Psychiatric Care   Yes   No   Weight Loss, unexplained   Yes   No   Psychiatric Care   Yes   No   No   No   Psychiatric Care   Yes   No   No   Psychiatric Care   No   Psychi	Course persistent or bleedy. Veg C No.	
Emphysema	O'chaire Diversity of the Community of t	
Do you wear contact lenses?   Yes   No   No   Nomen:  Are you pregnant?   Yes   No   Due date   Are you nursing?   Yes   No   Taking birth control pills?   Yes   No   No   No   No   No   No   No   N	Frankrisens Voc No.	
Barbiturates (Sleeping pills)		
Barbiturates (Sleeping pills)		ostbatio
Codeine	sis:	
UPDATES (To be filled in at future appointments)  Has there been any change in your health since your last dental appointment?	I I Barbiturates (Sleeping pills)   Penicillin	
UPDATES (To be filled in at future appointments)  Has there been any change in your health since your last dental appointment?		
UPDATES (To be filled in at future appointments)  Has there been any change in your health since your last dental appointment?   Yes   No  For what conditions?   If so, what?    Patient's Signature   Date    Doctor's Signature   Date    Has there been any change in your health since your last dental appointment?   Yes   No  For what conditions?   If so, what?    Are you taking any new medications?   If so, what?	☐ Codeine ☐ Sulfa	
Has there been any change in your health since your last dental appointment?	☐ Codeine ☐ Sulfa	
Has there been any change in your health since your last dental appointment?	☐ Codeine         ☐ Sulfa           Pharmacy Name         ☐ Iodine         ☐ Other	
For what conditions?  Are you taking any new medications?  Patient's Signature  Doctor's Signature  Date  Has there been any change in your health since your last dental appointment? Yes No  For what conditions?  Are you taking any new medications?  If so, what?	Codeine	
Are you taking any new medications? If so, what? Date Date Date Date Date Date Date	Codeine	
Patient's Signature	Codeine Sulfa I lodine Other  Chone ()  UPDATES (To be filled in at future appointments)  Has there been any change in your health since your last dental appointment? Yes No	
Doctor's Signature	Codeine Sulfa	
Has there been any change in your health since your last dental appointment?   Yes   No  For what conditions?   Are you taking any new medications?   If so, what?	Codeine Sulfa Charmacy Name I lodine Other Chone ()  UPDATES (To be filled in at future appointments)  Has there been any change in your health since your last dental appointment? Yes No  For what conditions?  Are you taking any new medications?  If so, what?	
For what conditions? If so, what? If so, what?	Codeine Sulfa	
For what conditions? If so, what? If so, what?	Codeine Sulfa	
Are you taking any new medications? If so, what?	Codeine Sulfa	
	Codeine   Sulfa     Indine   Other	
Patient's Signature Date	Codeine	
	Codeline	