# DENTAL REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date_____ ID#/SS#_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age_____Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation _____

Employer _____

_____

Employer Phone (_____) _____

Spouse's Name _____

Birthdate_____ SS#_____

Address (if different with above) _____

_____

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. _____

Group # _____

**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 changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

## 3 PHONE NUMBERS

Home(_____) _____ Work(_____ **Ext** _____ 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 _____

Home Phone (_____) _____ Work Phone (_____) _____

## 4 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 |
| Blisters 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 |
| Food collection between the teeth | ☐ Yes | ☐ No |
| Grinding teeth | ☐ Yes | ☐ No |
| Loose teeth or broken fillings | ☐ 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 |

How often do you floss?

How often do you brush?_____

_____