DENTAL REGISTRATION AND HISTORY

Date	PATIENT INFORMATI	ON	DENT	AL INSURANCE			
Paleint Name							
Patient Name Last Name L							
First Name Address E-mail City State Zip Birthdate Sex M F Age		Re	Relationship to Patient				
First Name Address E-mail City State Zip Birthdate Sex M F Age	Patient Name	Ins	surance Co				
Address E-mail Subscribers Name Birthdate SS# Subscribers Name Birthdate SS# Sitate Sitate		Gr	oup #				
Birthdate	First Name Middle Initial		Is patient covered by additional insurance? ☐ Yes ☐ No				
Birthdate	Address	Su	bscriber's Name				
Relationship to Patient Insurance Co. Group # ASSIGNMENT AND RELEASE I certify that it, and/or my dependent(s), have insurance coverage with Insurance Company(ies) AASIGNMENT AND RELEASE I certify that it, and/or my dependent(s), have insurance coverage with Insurance Company(ies) AASIGNMENT AND RELEASE I certify that it, and/or my dependent(s), have insurance coverage with Insurance Company(ies) AASIGNMENT AND RELEASE I certify that it, and/or my dependent(s), have insurance coverage with Insurance Company(ies) AASIGNMENT AND RELEASE I certify that it, and/or my dependent(s), have insurance coverage with Insurance Submance to Insurance Company(ies) AASIGNMENT AND RELEASE I certify that it, and/or my dependent(s), have insurance coverage with Insurance Submance to Insurance Submance to Insurance Submance Ins							
Insurance Co.							
Sex M F Age			elationship to Patie	ent			
Birthdate Married Widowed Single Milnor Sagantared Divorced Partnered foryears Patient Employer/School Dr	State Zip		surance Co				
Married Widowed Single Minor Separated Divorced Partnered for years Name of Insurance Company(ies) and assign directly to Name of Insurance Submissions. Dr	Sex M F Age	Gr	oup #				
Married microwed	Birthdate						
Separated Ovorced Partnered for	☐ Married ☐ Widowed ☐ Single	☐ Minor	certify that I, and	or my dependent(s), have insuran	ce coverage with		
Patient Employer/School	☐ Separated ☐ Divorced ☐ Partnered	for years	Name of In	surance Company(ies) and	assign directly to		
Agriculture of Patient, Parent, Guardian or Personal Representative Spouse's Work Date Mouth preating Phone Dental History Spouse's Work Destroy Spouse's Work Spouse's Wo					6		
Employer/School Address		an					
Employer/School Address	Occupation				surance. I authorize		
such information to the above-named insurance Company(se) and their agents for the purpose of obtaining 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	Employer/School Address				n and may disclose		
Employer/School Phone (-	suc	ch information to the	above-named Insurance Company(ies	s) and their agents		
Signature of Patient, Parent, Guardian or Personal Representative	Employer/School Phone ()	tor					
Signature of Patient, Parent, Guardian or Personal Representative	Spouse's Name		current treatment p	an is completed or one year from the o	date signed below.		
SS#							
Spouse's Employer			Signature of Pat	tient, Parent, Guardian or Personal Rep	presentative		
Date Relationship to Patient	SS#		Please print name o	f Patient, Parent, Guardian or Personal	Representative		
PHONE NUMBERS Phone (Spouse's Employer						
Phone (Whom may we thank for referring you?		Date	Relationship to	o Patient		
Phone (
Spouse's Work (PHONE NUMBERS	7 - 7 - 1					
Spouse's Work (
Name Relationship Work Phone (
Relationship Home Phone (
DENTAL HISTORY Reason for today's visit	IN CASE OF EMERGENCY, CONTACT (Specify	someone who does not live in you	r household.)				
Place a mark on "yes" or "no" to indicate if you have had any of the following: Burning sensation on tongue Yes No Mouth breathing Yes No No Mouth pain, brushing Yes No No Orthodontic treatment Yes No Orthodontic treatment Yes No No Orthodontic treatment Yes No Pain around ear Yes No No Pain around ear Yes No No Pain around ear Yes No Pain around ear Yes No No Pain around ear	Name	Relation	onship				
Reason for today's visit Burning sensation on tongue Yes No No	Home Phone ()	Work F	Phone ()_				
Reason for today's visit Burning sensation on tongue Yes No No							
Chew on one side of mouth	DENTAL HISTORY						
Chew on one side of mouth	Reason for today's visit	Burning concetion on tangua	□Vos □No	Mouth broathing	□Vos □No		
Cigarette, pipe, or cigar smoking	Heason for today's visit						
City/State							
Date of last dental visit Fingernail biting Yes No Sensitivity to cold Yes No Date of last dental X-rays Foreign objects Yes No Sensitivity to heat Yes No Place a mark on "yes" or "no" to indicate if you have had any of the following:	Former Dentist				☐ Yes ☐ No		
Date of last dental visit Food collection between the teeth	City/State						
Date of last dental X-rays Foreign objects	Date of last dental visit		The second secon				
Place a mark on "yes" or "no" to indicate if you have had any of the following: Bad breath Gums swollen or tender Gums swollen or tender Yes No Sensitivity when biting Yes No Sores or growths in your mouth Yes No How often do you floss? How often do you floss?	Date of last dental X-rays						
have had any of the following: Gums swollen or tender Yes No Sores or growths in your mouth Yes No Bad breath Yes No Jaw pain or tiredness How often do you floss? How often do you floss?							
Bleeding gums							
Bleeding gums				How often do you floss?			
			The second secon				

HEALTH HISTORY								
Bhusiaisa la Nassa								
Physician's Name Date of last visit Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.								
				mbinations of Ionimin, Adipex, Fa				
names of phentermine), Pond	dimin (fenfluramine)	and Redux (dexfenfluramin	e). 🗌 Yes 🔲 No					
Place a mark on "yes" or "no" AIDS/HIV	Yes No	Epilepsy	: □ Yes □ No	Respiratory Disease	☐ Yes ☐ No			
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No			
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No			
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No			
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No			
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No			
Back Problems	☐ Yes ☐ No	Hepatitis Type	Yes 🗆 No	Special Diet	☐ Yes ☐ No			
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No			
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No			
Cancer	☐ Yes ☐ No	Jaundice Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands Thyroid Problems	☐ Yes ☐ No			
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems Tonsillitis	☐ Yes ☐ No			
Chemotherapy	☐ Yes ☐ No	Liver Disease	Yes No	Tuberculosis	☐ Yes ☐ No			
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or	☐ Yes ☐ No			
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	neck				
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No			
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No			
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No			
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No					
Do you wear contact lenses?	☐ Yes ☐ No							
Women:	□No	Due data	Are you no	roing? □ Voc. □ No.				
Taking birth control pills?	Are you pregnant? Yes No Due date Are you nursing? Yes No							
		S		ALLERGIES				
MEI	DICATIONS		□ Accirio		io			
	DICATIONS		☐ Aspirin	☐ Local Anesthet	ic			
MEI List any medications you are o	DICATIONS		☐ Aspirin ☐ Barbiturates (Sleepin	☐ Local Anesthet	iic			
MEI List any medications you are o	DICATIONS			☐ Local Anesthet	iic			
MEI List any medications you are o	DICATIONS currently taking and	the correlating	☐ Barbiturates (Sleepin	☐ Local Anesthet				
MEI List any medications you are of diagnosis:	DICATIONS currently taking and	the correlating	☐ Barbiturates (Sleepin☐ Codeine	☐ Local Anesthet g pills) ☐ Penicillin ☐ Sulfa				
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