DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

Marital Status _____

Patient SS# _____

Patient Drivers License # _____

Occupation _____

Employer _____

Employer Address _____

_____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Work # _____

Referred By _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Address: _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Address: _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Staller 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 PHONE NUMBERS

Home _____ Work _____ Ext_____ Cell Phone _____

Best time and place to reach you _____ Email Address _____

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 _____

_____

Dentist _____

Address _____

City/State _____

Telephone _____

Date of last cleaning _____

Date of last dental exam _____

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

Gums swollen or tender ☐ Yes ☐ No

Loose teeth ☐ Yes ☐ No

Mouth pain, brushing ☐ Yes ☐ No

Sensitivity to cold & heat ☐ Yes ☐ No

Sensitivity to sweets ☐ Yes ☐ No

Sensitivity when biting ☐ Yes ☐ No

Blisters on lips or mouth ☐ Yes ☐ No

Chew on one side of mouth ☐ Yes ☐ No

Cigarette, pipe, or cigar smoking ☐ Yes ☐ No

How long_____ How much_____

Clicking or popping jaw ☐ Yes ☐ No

Dry Mouth ☐ Yes ☐ No

Food collection between the teeth ☐ Yes ☐ No

Grinding or clench teeth ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No

Previous periodontal treatment ☐ Yes ☐ No

Trench Mouth ☐ Yes ☐ No

Orthodontic treatment ☐ Yes ☐ No

How often do you floss? _____

How often do you brush? _____

Brush type:

Soft Medium Hard

(over)

5 HEALTH HISTORY

Physician's Name _____ Tel# _____ Date of last visit _____

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

Anemia	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Chemical Dependency	☐ Yes	☐ No	Women:		
Artificial Heart Valves	☐ Yes	☐ No	Circulatory Problems	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Cortisone Treatments	☐ Yes	☐ No	Due Date_____		
Heart Murmur	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Type_____			Hormone Replacement	☐ Yes	☐ No
Heart Problems _____	☐ Yes	☐ No	Frequent Urination	☐ Yes	☐ No	Birth Control Pills	☐ Yes	☐ No
_____			Emphysema	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No	Type _____			Thyroid Problems	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tumor or growth on		
Artificial Joints	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	head or neck	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Type _____			Ulcer	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Bleeding abnormally, with			High Risk for AIDS	☐ Yes	☐ No	Weight Loss,	☐ Yes	☐ No
extractions or surgery	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	unexplained		
Blood Disease	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Do you need to Pre-Medicate?	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Why? _____		
Chemotherapy	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	If so, what with? _____		

MEDICATIONS

List prescribed and over the counter medications you are currently taking or have taken during the last 6 months:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

☐ Aspirin/Ibuprophen ☐ Novocaine & Dental Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin or other Antibiotics

☐ Codeine ☐ Sulfa

☐ Latex ☐ Other _____

6 SUMMARY OF MEDICAL HISTORY

_____

_____

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health or in my medicines, I will inform the doctor of dentistry at the next appointment without fail.

So that we may maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees. Once you have made an appointment, remember this time is reserved for you – therefore, **AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY, OTHERWISE THE USUAL FEE CHARGE WILL BE MADE.**

I ACCEPT RESPONSIBILITY

Signature _____ Date _____

Parent or Guardian (if minor) _____

Reviewed by _____ Date _____