DENTAL REGISTRATION AND HISTORY

PATIENT INFORMAT	ION	DENTAL INSURANCE					
Date		/ho is responsible for this account?					
SS/HIC/Patient ID #		elationship to Patient					
Patient Name	Ins	surance Co.					
		Group #					
First Name	Middle Initial Is	patient covered by additional insurance? $\hfill\square$ Yes	□ No				
Address	Su	ubscriber's Name					
E-mail	Bir	irthdate SS#					
City		elationship to Patient					
State Zip		surance Co.					
Sex DM F Age		roup #					
Birthdate							
☐ Married ☐ Widowed ☐ Single		SSIGNMENT AND RELEASE certify that I, and/or my dependent(s), have insur-	ance coverage with				
☐ Separated ☐ Divorced ☐ Partnered	for years		and assign directly to				
Patient Employer/School		Name of Insurance Company(ies)					
	Dr.	rall ny, otherwise payable to me for services rendered. I u					
Occupation	fina	e use of my signature on all insurance submissions.					
Employer/School Address			" mou dipalona				
	suc	ne above-named dentist may use my health care information in the above-named Insurance Company	(ies) and their agents				
Employer/School Phone ()	ber	r the purpose of obtaining payment for services and denefits or the benefits payable for related services. This c	consent will end when				
Spouse's Name	my	y current treatment plan is completed or one year from the	e date signed below.				
Birthdate							
SS#		Signature of Patient, Parent, Guardian or Personal P	Representative				
Spouse's Employer		Please print name of Patient, Parent, Guardian or Person	nal Representative				
Whom may we thank for referring you?							
Wildin may we thank for following you.		Date Relationship	to Patient				
9	No feet and the second second						
PHONE NUMBERS							
Home ()	Work ()	Ext Cell Phone ()					
Spouse's Work ()		u					
IN CASE OF EMERGENCY, CONTACT (Specify							
Name	Relation	onship					
Home Phone ()		Phone ()					
Trome : Trome (TO	Filone ()					
DENTAL HISTORY							
Reason for today's visit	Burning sensation on tongue	Yes No Mouth breathing	☐ Yes ☐ No				
	Chew on one side of mouth Cigarette, pipe, or cigar smoking	☐ Yes ☐ No Mouth pain, brushing ☐ Yes ☐ No 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 teeth		☐ Yes ☐ No				
	Foreign objects Grinding teeth	☐ Yes ☐ No Sensitivity to sweets ☐ Yes ☐ No Sensitivity when biting	☐ Yes ☐ No				
Place a mark on "yes" or "no" to indicate if you 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	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?					

HEALTH H	1151	0 44 4							-
Physician's Name						Date of	last visit		
Have you ever taken any of the			lectively referred to as "fe	n-nhen?" These	include co			estin (bran	nd
names of phentermine), Pond						mbiriationo c	or remain, Adipox, re	iotiii (biai	10
Place a mark on "yes" or "no"	' to indica	te if you hav	ve had any of the following	j:					
AIDS/HIV	☐ Yes	□No	Epilepsy	☐ Yes	☐ No	Respirat	ory Disease	☐ Yes	□ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ Yes ☐ No Rheumatic Fever		Yes	☐ No	
Arthritis, Rheumatism	☐ Yes	□No	Glaucoma	☐ Yes	☐ No	Scarlet F	ever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortnes	ss of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	□No	Heart Murmur	☐ Yes	☐ No	Sinus Tro	ouble	Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash		☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type	Yes	☐ No	Special I	Diet	☐ Yes	□ No
Bleeding abnormally, with extractions or surgery	☐ Yes	□ No	Herpes High Blood Pressure	☐ Yes ☐ Yes		Stroke Swollen Feet or Ankles			
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands		☐ Yes	□ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	□No	Thyroid Problems		☐ Yes	□ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	□ No	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	□ N
Congenital Heart Lesions	☐ Yes	□No	Mitral Valve Prolapse	☐ Yes	□No	neck			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	Yes	□No	Ulcer		☐ Yes	
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease		☐ Yes	
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight L	oss, unexplained	☐ Yes	
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No				
Are you pregnant?		ALLERGIES							
		☐ Aspirin			☐ Local Anesthet	ic			
		☐ Barbiturates (Sleeping pills)			☐ Penicillin	☐ Penicillin			
				☐ Codeine			Sulfa		
Pharmacy Name			□ lodine			☐ Other			
Phone ()			Latex						
UPDATES	(To be	filled in a	at future appointmen	nts)					
Has there been any change	in your he	ealth since y	our last dental appointme	nt? 🗌 Yes 🗆	No				
For what conditions?									
Are you taking any new med	ications?_		If so, what?						
	ications?_		If so, what?				Date		
Are you taking any new med Patient's Signature	ications?_		If so, what?				Date Date		
Are you taking any new med Patient's Signature Doctor's Signature	ications?	•••••	If so, what?		•••••		Date Date		
Are you taking any new med Patient's Signature Doctor's Signature Has there been any change	ications?_	ealth since y	If so, what? our last dental appointme	nt? □ Yes □	No	••••••	Date Date		
Are you taking any new med Patient's Signature Doctor's Signature Has there been any change For what conditions?	ications?_	ealth since y	If so, what? our last dental appointme	nt?	No	••••••	Date Date		•••••
Doctor's Signature	ications?_	ealth since y	If so, what? our last dental appointme If so, what?	nt? □ Yes □	No	••••••	Date Date		