DENTAL REGISTRATION AND HISTORY

Patient Information

Today's Date____

Patient____

Preferred Name (Nickname)_______________________________________

Address ____

____
City State Zip

Home Phone ___________________ Cell Phone______________________

Sex: ☐ M ☐ F Age___________ Birth date_________________________

SS#______________________ Email____________________________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Minor

Occupation ____

Employer ______________________________Phone___________________

Spouse's or Legal Guardian's Name ___________________________________

Date of Birth _______________ SS#______________________

Employer ____

Work Number____

Who is responsible for this account? ________________________________

IN CASE OF EMERGENCY, CONTACT

(Specify someone who DOES NOT live in your household)

Name _____________________________ Home number_________________

Relationship________________________ Work number_________________

Whom may we thank for referring you? _____________________________

Dental Insurance

Subscriber's name____

Subscriber's SS#_______________________ Date of Birth________________

Relationship to Patient____

Insurance Company____

Group#____

Is Patient covered by additional dental insurance? ☐Yes ☐ No

Secondary Subscriber's Name____

Secondary Subscriber's SS#________________ Birth date________________

Insurance Company ____

Group# ____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________________________ and assign directly to Dr. Ann Miller 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 also understand I will be responsible for any participating provider adjustments if co-payment is not received within the terms of said contract. I authorize the use of this signature on all insurance submissions.

_________________________________ ____________________
Responsible Party Signature Date

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" if you have had Any of the following:

Bad Breath	☐Yes ☐ No
Bleeding gums	☐Yes ☐No
Blisters on lips or mouth	☐Yes ☐ No
Lip or cheek biting	☐Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No
Chew on one side	☐ Yes ☐ No
Cigarette, pipe, or Cigar smoking	☐ Yes ☐ No
Clicking or popping jaw	☐ Yes ☐ No
Dry mouth	☐ Yes ☐ No
Fingernail biting	☐ Yes ☐ No
Food Collection between the teeth	☐ Yes ☐ No
Foreign objects	☐ Yes ☐ No
Gums swollen or tender	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No
Jaw pain or tiredness	☐ Yes ☐ No
Loose teeth or broken fillings	☐ Yes ☐ No
Mouth breathing	☐ Yes ☐ No
Mouth pain, brushing	☐ Yes ☐ No
Orthodontic treatment	☐ Yes ☐ No
Pain around ear	☐ Yes ☐ No
Periodontal Treatment	☐ Yes ☐ No
Sensitivity to cold	☐ Yes ☐ No
Sensitivity to sweets	☐ Yes ☐ No
Sensitivity when biting	☐ Yes ☐ No
Sores or growths in your mouth	☐ Yes ☐ No

How often do you floss? _______________

How often do you brush? _______________

Health History

Family Physician's Name ____ Date of last visit ____

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

Heart Problems	☐Yes ☐No	Autoimmune Disease	☐Yes ☐No	Back Problems	☐Yes☐No
High Blood Pressure	☐Yes ☐No	Scarlet Fever	☐Yes ☐No	Swollen Feet or Ankles	☐Yes ☐No
Low Blood Pressure	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Heart Attack	☐Yes ☐No	Asthma	☐Yes☐ No	Swollen Neck Glands	☐Yes ☐No
Stroke	☐Yes☐ No	Cough, persistent or bloody	☐Yes ☐No	Special Diet	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Emphysema	☐Yes ☐No	Contact Lenses?	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Shortness of breath	☐Yes ☐No	AIDS/HIV	☐Yes ☐No
Mitral Valve Prolapse	☐Yes ☐No	Respiratory Disease	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Pacemaker	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Herpes	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Arthritis, Rheumatism	☐Yes ☐No	Unexplained weight loss	☐Yes ☐No
Anemia	☐Yes ☐No	Cortisone treatments	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Blood Disease	☐Yes ☐No	Tumor or growth on head or neck	☐Yes ☐No	Nervous Problems	☐Yes ☐No
Abnormal Bleeding	☐Yes ☐No	Cancer	☐Yes ☐No	Depression	☐Yes☐ No
Fainting	☐Yes ☐No	Radiation or Chemotherapy	☐Yes ☐No		
Diabetes	☐Yes ☐No	Epilepsy	☐Yes ☐No	**WOMEN ONLY:**	
Hepatitis type ____	☐Yes ☐No	Glaucoma	☐Yes ☐No	Are you pregnant	☐Yes ☐No
Jaundice	☐Yes ☐No	Headaches	☐Yes☐No	Due Date __________________	
Liver Disease	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Taking Birth Control	☐Yes ☐No
Kidney Disease	☐Yes ☐No	Ulcers	☐Yes ☐No	Are you breast feeding	☐Yes ☐No

⌘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). ☐Yes ☐No

⌘If yes, have you ever had an echocardiogram? ☐Yes ☐No

⌘Do you need to take antibiotics prior to dental visits due to artificial valves, artificial joints, heart murmur or mitral valve prolapse? ☐ Yes ☐ No

⌘List any surgeries and dates of surgeries____

Medications

Pharmacy Preferred____

Phone ____

List any medications you are currently taking, whether prescribed by your physician, over the counter, or herbal supplements.

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Allergies

☐ Aspirin

☐ Barbiturates (Sleeping pills)

☐ Codeine

☐ Iodine

☐ Other

☐ Local Anesthetic

☐ Penicillin

☐ Sulfa

☐ Latex

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