

# REGISTRATION AND HISTORY

## 1 Patient Information

Date \_\_\_\_\_

SS/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthday \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_yrs

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

\_\_\_\_\_  
 Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

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?  Y  N

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/Pt. ID \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to **Dr. Christine**  
Nzme of Insurance Company(ies)

**Saad** 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining 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

\_\_\_\_\_  
 Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

## 3 Phone Numbers

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_

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 _____	Chew on one side of mouth <input type="checkbox"/> Y <input type="checkbox"/> N	Mouth Breathing <input type="checkbox"/> Y <input type="checkbox"/> N
_____	Cigarette, pipe, or cigar <input type="checkbox"/> Y <input type="checkbox"/> N	Mouth pain <input type="checkbox"/> Y <input type="checkbox"/> N
Former Dentist _____	Clicking/Popping Jaw <input type="checkbox"/> Y <input type="checkbox"/> N	Orthodontics <input type="checkbox"/> Y <input type="checkbox"/> N
City/State _____	Dry Mouth <input type="checkbox"/> Y <input type="checkbox"/> N	Pain around the ear <input type="checkbox"/> Y <input type="checkbox"/> N
Date of last dental visit _____	Fingernail biting <input type="checkbox"/> Y <input type="checkbox"/> N	Periodontal treatment <input type="checkbox"/> Y <input type="checkbox"/> N
Date of last dental x-rays _____	Food Collection between teeth <input type="checkbox"/> Y <input type="checkbox"/> N	Sensitivity to cold <input type="checkbox"/> Y <input type="checkbox"/> N
<b>Place a mark on "yes" or no" to indicate</b>	Foreign objects <input type="checkbox"/> Y <input type="checkbox"/> N	Sensitivity to head <input type="checkbox"/> Y <input type="checkbox"/> N
<b>If you have had any of the following:</b>	Grinding teeth <input type="checkbox"/> Y <input type="checkbox"/> N	Sensitivity to sweets <input type="checkbox"/> Y <input type="checkbox"/> N
Bad Breath <input type="checkbox"/> Y <input type="checkbox"/> N	Gums swollen or tender <input type="checkbox"/> Y <input type="checkbox"/> N	Sensitivity when biting <input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Gums <input type="checkbox"/> Y <input type="checkbox"/> N	Jaw Pain or tiredness <input type="checkbox"/> Y <input type="checkbox"/> N	Sores or growths in mouth <input type="checkbox"/> Y <input type="checkbox"/> N
Blisters on Lips or Mouth <input type="checkbox"/> Y <input type="checkbox"/> N	Lip or Cheek biting <input type="checkbox"/> Y <input type="checkbox"/> N	How often do you floss? _____
Burning Sensation on tongue <input type="checkbox"/> Y <input type="checkbox"/> N	Loose teeth or broken fillings <input type="checkbox"/> Y <input type="checkbox"/> N	How often do you brush? _____

## 5 Health History

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of loimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). \_\_\_Y \_\_\_N

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

AIDS/HIV	___Y ___N	Epilepsy	___Y ___N	Respiratory Disease	___Y ___N
Anemia	___Y ___N	Fainting or dizziness	___Y ___N	Rheumatic Fever	___Y ___N
Arthritis, Rheumatism	___Y ___N	Glaucoma	___Y ___N	Scarlet Fever	___Y ___N
Artificial Heart Valves	___Y ___N	Headaches	___Y ___N	Shortness of Breath	___Y ___N
Artificial Joints	___Y ___N	Heart Murmur	___Y ___N	Sinus Trouble	___Y ___N
Asthma	___Y ___N	Heart Problems	___Y ___N	Skin Rash	___Y ___N
Back Problems	___Y ___N	Hepatitis Type___	___Y ___N	Special Diet	___Y ___N
Bleeding abnormally, with		Herpes	___Y ___N	Stroke	___Y ___N
Extractions or surgery	___Y ___N	High Blood Pressure	___Y ___N	Swollen Feet or Ankles	___Y ___N
Blood Disease	___Y ___N	Jaundice	___Y ___N	Swollen Neck Glands	___Y ___N
Cancer	___Y ___N	Jaw Pain	___Y ___N	Thyroid Problems	___Y ___N
Chemical Dependency	___Y ___N	Kidney Disease	___Y ___N	Tonsillitis	___Y ___N
Chemotherapy	___Y ___N	Liver Disease	___Y ___N	Tuberculosis	___Y ___N
Circulatory Problems	___Y ___N	Low Blood Pressure	___Y ___N	Tumor or growth on head	
Congenital Heart Lesions	___Y ___N	Mitral Valve Prolapse	___Y ___N	or neck	___Y ___N
Cortisone Treatments	___Y ___N	Nervous Problems	___Y ___N	Ulcer	___Y ___N
Cough, persistent/bloody	___Y ___N	Pacemaker	___Y ___N	Venereal Disease	___Y ___N
Diabetes	___Y ___N	Psychiatric Care	___Y ___N	Wear contact lenses	___Y ___N
Emphysema	___Y ___N	Radiation Treatment			

**Women:** Are you pregnant? \_\_\_Y \_\_\_N Due Date \_\_\_\_\_ Are you nursing? \_\_\_Y \_\_\_N  
Taking birth control pills? \_\_\_Y \_\_\_N

MEDICATIONS	ALLERGIES
List any medications you are currently taking and the correlating diagnosis: _____ _____ _____	___ Aspirin ___ Barbiturates (Sleeping Pills) ___ Codeine ___ Iodine ___ Latex
Pharmacy Name _____ Phone(____)_____	___ Local Anesthetic ___ Penicillin ___ Sulfa ___ Other _____ _____

## 6 Updates (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? \_\_\_Y \_\_\_N

For what conditions? \_\_\_\_\_

Are you taking new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

---

Has there been any change in your health since your last dental appointment? \_\_\_Y \_\_\_N

For what conditions? \_\_\_\_\_

Are you taking new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_