# DENTAL REGISTRATION AND HISTORY

## PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age ____ Birth Date _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birth Date _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

## DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name

Birth date _____ SS# ____ - ____ - ____

Relationship to Patient _____

Insurance Co. _____

Group # _____

### ASSIGNMENT AND RELEASE

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

## PHONE NUMBERS

Home _____ Work _____ Ext _____ 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 _____

## 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" to indicate if you have had any of the following:

| | | |
|---|---|---|
| Bad breath | ☐Yes | ☐No |
| Bleeding gums | ☐Yes | ☐No |
| Blisters on lips or mouth | ☐Yes | ☐No |
| Burning sensations on tongue | ☐Yes | ☐No |
| Chew on one side of mouth | ☐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 |
| Grinding teeth | ☐Yes | ☐No |
| Gums swollen or tender | ☐Yes | ☐No |
| Jaw pain or tiredness | ☐Yes | ☐No |
| Lip or cheek biting | ☐Yes | ☐No |
| Loose teeth or broken fillings | ☐Yes | ☐No |
| Mouth breathing | ☐Yes | ☐No |
| Mouth pain, while brushing | ☐Yes | ☐No |
| Orthodontic treatment | ☐Yes | ☐No |
| Pain around ear | ☐Yes | ☐No |
| Periodontal treatment | ☐Yes | ☐No |
| Sensitivity to cold | ☐Yes | ☐No |
| Sensitivity to heat | ☐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? _____

*See Other Side*

# HEALTH HISTORY

Physician's Name _____ Phone Number _____

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

| | | | | | |
|---|---|---|---|---|---|
| *Heart:* | | | Artificial Bone or Joint | ☐Yes | ☐No |
| Artificial Heart Valves | ☐Yes | ☐No | AIDS | ☐Yes | ☐No |
| Congenital Heart Lesion | ☐Yes | ☐No | Anemia | ☐Yes | ☐No |
| Heart Murmur | ☐Yes | ☐No | Arthritis | ☐Yes | ☐No |
| Heart Stint or Shunt | ☐Yes | ☐No | Back Problems | ☐Yes | ☐No |
| High Blood Pressure | ☐Yes | ☐No | Bleeding abnormally, with extractions | ☐Yes | ☐No |
| Low Blood Pressure | ☐Yes | ☐No | Cancer (Radiation tx) | ☐Yes | ☐No |
| Mitral Valve Prolapse | ☐Yes | ☐No | Diabetes | ☐Yes | ☐No |
| Pacemaker | ☐Yes | ☐No | Epilepsy | ☐Yes | ☐No |
| Rheumatic Fever | ☐Yes | ☐No | Headaches | ☐Yes | ☐No |
| Scarlet Fever | ☐Yes | ☐No | Hepatitis | ☐Yes | ☐No |
| Stroke | ☐Yes | ☐No | Type_____ | | |
| | | | HIV Positive | ☐Yes | ☐No |
| *Lung:* | | | Jaw Pain | ☐Yes | ☐No |
| Asthma | ☐Yes | ☐No | Kidney Disease | ☐Yes | ☐No |
| Cough, persistent or bloody | ☐Yes | ☐No | Psychiatric Care | ☐Yes | ☐No |
| C.O.PD. | ☐Yes | ☐No | Thyroid Problems | ☐Yes | ☐No |
| Emphysema | ☐Yes | ☐No | *Women:* | | |
| Respiratory Disease | ☐Yes | ☐No | Are you pregnant? | ☐Yes | ☐No |
| Shortness of Breath | ☐Yes | ☐No | Due date_____ | | |
| Tuberculosis | ☐Yes | ☐No | Are you nursing? | ☐Yes | ☐No |

How often do you take aspirin? _____

What other serious illnesses or injuries have you had? ____None

_____

_____

What operations or surgeries have you had? ____None

_____

_____

What medicine or pills are you taking now? (i.e. Blood Thinners, Herbs, Vitamins) ____None

_____

_____

What medication(s) are you allergic to? (i.e. PCN, Sulfa, Etc.) ____None

_____

_____

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

_____ / _____

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY DR'S INITIALS

MEDICAL UPDATE: I HAVE READ MY HEALTH HISTORY DATED ____/____/____ AND CONFIRM THAT IT ADEQUATELY STATES PAST AND PRESENT CONDITIONS.

| DATE | EXCEPTIONS OR CHANGES | PATIENT'S SIGNATURE | DOCTOR'S INITIALS |
|---|---|---|---|
| | | | |
| DATE | EXCEPTIONS OR CHANGES | PATIENT'S SIGNATURE | DOCTOR'S INITIALS |
| | | | |

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, in refusing we
*will not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the office of DR. DENISE ANDERSON, DMD, PA. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

---

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Email Confirmation @ _____

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Email Message @ _____
- ☐ In-Person
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW DENTAL INFO** via:

- ☐ Phone Message
- ☐ Email @ _____
- ☐ **Any of the above**

---

**Office Use Only**
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer