

# DENTAL REGISTRATION AND HISTORY

## PATIENT INFORMATION

Date \_\_\_\_\_ ID# / SS# \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

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

Email \_\_\_\_\_

Sex: M  F  Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's or Parent's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ 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 \_\_\_\_\_

Birthdate \_\_\_\_\_ 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. Nelson 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 \_\_\_\_\_ 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 (\_\_\_\_\_) \_\_\_\_\_

## 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:	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Cigarette, pipe or cigar smoke <input type="checkbox"/> Yes <input type="checkbox"/> No Chew tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No Dry Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw pain or tenderness <input type="checkbox"/> Yes <input type="checkbox"/> No Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding when brushing <input type="checkbox"/> Yes <input type="checkbox"/> No Orthodontic Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No How often do you floss? _____ How often do you brush? _____
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## 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 Lonimin, Adipex, Fastin ( brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

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

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough, persistant or bloody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Women:  
 Are you pregnant?  Yes  No      Due Date \_\_\_\_\_      Are you nursing?  Yes  No  
 Taking birth control pills?  Yes  No

### MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_  
 Phone (\_\_\_\_\_) \_\_\_\_\_

### ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	<input type="checkbox"/> -----

## CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in cash at the time of services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charges on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value fo said services to said Doctor, or his assignee, at the time said servies are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value or said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I granted my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

\_\_\_\_\_  
 Signature of patient, parent or guardian      Date: \_\_\_\_\_      Relation to Patient: \_\_\_\_\_

\_\_\_\_\_  
 Signature of guarantor or payment / responsible party      Date: \_\_\_\_\_      Relation to Patient: \_\_\_\_\_