

# PATIENT REGISTRATION

DATE: \_\_\_\_\_

## PATIENT INFORMATION

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

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

Address \_\_\_\_\_

City \_\_\_\_\_

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

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

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

Birthdate \_\_\_\_\_

 Married  Widowed  Single  Minor Separated  Divorced  Partnered

Occupation \_\_\_\_\_

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

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

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

Birthdate \_\_\_\_\_

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

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

Whom May We Thank For Referring You? \_\_\_\_\_

## DENTAL INSURANCE

Responsible Party for this account? \_\_\_\_\_

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

Insurance Company \_\_\_\_\_

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

Additional Insurance Coverage?  Yes  No

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

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

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

Name of Insurance Company \_\_\_\_\_

and assign directly to **Dr. J. Gary Williams or Today's Family Dental** 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 and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

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

Date \_\_\_\_\_

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

## PHONE NUMBERS

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ 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 \_\_\_\_\_

**Circle "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 feeling on tongue Yes No

Chew on one side Yes No

Smoker Yes No

Clicking or popping jaw Yes No

Dry Mouth Yes No

Fingernail biting Yes No

Food collects between 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, 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 mouth Yes No

How often do you floss? \_\_\_\_\_

How often do you brush? \_\_\_\_\_

# PATIENT REGISTRATION

DATE: \_\_\_\_\_

## 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?"  Yes  No

**Please circle "Yes" or "No" to indicate if you have had any of the following:**

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Radiation Treatment	Yes	No
Anemia	Yes	No	Fainting or dizziness	Yes	No	Respiratory Disease	Yes	No
Arthritis, Rheumatism	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Scarlet Fever	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Shortness of Breath	Yes	No
Asthma	Yes	No	Heart Problems	Yes	No	Sinus Trouble	Yes	No
Back Problems	Yes	No	Hepatitis TYPE _____	Yes	No	Skin Rash	Yes	No
Bleeding abnormally	Yes	No	Herpes	Yes	No	Special Diet	Yes	No
Blood Disease	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Jaundice	Yes	No	Swollen Feet or Ankles	Yes	No
Chemical Dependency	Yes	No	Jaw Pain	Yes	No	Swollen Neck Glands	Yes	No
Chemotherapy	Yes	No	Kidney Disease	Yes	No	Thyroid Problems	Yes	No
Circulatory Problems	Yes	No	Liver Disease	Yes	No	Tonsillitis	Yes	No
Congenital Heart Problems	Yes	No	Low blood Pressure	Yes	No	Tuberculosis	Yes	No
Cortisone Treatments	Yes	No	Mitral Valve Prolapse	Yes	No	Tumor or Growth on head or neck	Yes	No
Coughing	Yes	No	Nervous Problems	Yes	No	Ulcer	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No	Unexplained Weight Loss	Yes	No
Emphysema	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No

Do you wear contact lenses? Yes 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 reason for taking:

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Pharmacy Name \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

### 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                         | _____                                     |