

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Today's Date _____

Patient Name _____
First Middle Initial

Last Preferred Name

Address _____

City _____

State _____ Zip _____

Sex M F

Birth date _____

SS# _____

Married Widowed Single Minor
 Separated Divorced Partnered for ___ years

Patient Employer/School _____

Occupation _____

Address _____

 Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account?

Relationship to patient _____

Insurance Co. _____

Phone Number _(_____)_____

Subscriber's Name _____

Birth Date _____ SS# _____

Relationship to Patient _____

Is patient covered by additional insurance? Y N

If yes:

Insurance Co. _____

Phone Number _(_____)_____

Subscriber's Name _____

Birth Date _____ SS# _____

Relationship to Patient _____

Assignment and Release

I certify that I, and/or dependent(s), have insurance coverage with _____ and assign directly to Amy M. Kimes, D.D.S., P.A., all insurance benefits, if any, otherwise payable to this office 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 my 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.

Signature of Person responsible for this account

Please print name

Date

Relationship to Patient

PHONE NUMBERS

Home (_____) _____

Cell (_____) _____

Work (_____) _____

Other (_____) _____

IN CASE OF EMERGENCY, CONTACT (someone who does not live in your household)

Name _____

Phone Number (_____) _____

Relationship _____

DENTAL HISTORY

Reason for today's visit _____
 Former Dentist _____
 City/State _____
 Date of last visit _____
 Date of last dental X-rays _____
 How often do you floss? _____
 How often do you brush? _____

Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foreign objects	<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 tiredness	<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
Mouth pain, 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 mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Use of tobacco products	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mark "Yes" or "No" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips/mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
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

ALLERGIES

Aspirin Codeine Iodine Latex Local Anesthetic Penicillin Sulfa
 Other: _____

MEDICATIONS

*Have you ever taken any of the drugs referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) Yes No

*Do you now, or have you ever taken medication for Osteoporosis? Yes No

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

Pharmacy Name _____ Phone (____) _____

Location/address _____

HEALTH HISTORY

Physician's Name _____

Phone # (____) _____

Date of last visit _____

Mark "Yes" or "No" to indicate if you have had any of the following:

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

For Women:

 Are you pregnant? Yes, due date _____ No

 Are you nursing? Yes No

 Taking birth control pills? Yes No

I have filled out this information to the best of my ability and knowledge. I understand that I am responsible for making this office aware of any changes or updates to any information given in this paperwork. I also understand that I am responsible for any charges incurred in this office on the day of service unless other arrangements have previously been made with this office.

Signature _____ Date _____

Printed Name _____ Witness _____

Doctor's Signature _____ Date _____