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? _____

_____

PHONE NUMBERS

Home (_____)_____

Cell (_____)_____

Work (_____)_____

Other (_____)_____

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

Phone Number (____)_____

Relationship _____

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

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? _____

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

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips/mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Food collection 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
Use of tobacco products	☐ Yes	☐ 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	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Bleeding abnormally, after extractions or surgery	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
		Scarlet Fever	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Tobacco use	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Tumor or growth on head/neck	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Hepatitis Type ____	☐ Yes ☐ No	Do you wear contact lenses?	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	Other _____	
High/Low Blood Pressure	☐ Yes ☐ No		
Jaundice	☐ Yes ☐ No		
Jaw Pain	☐ Yes ☐ No		
Kidney Disease	☐ Yes ☐ No		
Liver Disease	☐ Yes ☐ 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_____