## **DENTAL REGISTRATION AND HISTORY**

		ION	- DEITH	TAL INSURANCE		
Date			Who is responsible	for this account?		
SS/HIC/Patient ID #			Relationship to Pat	Patient		
Patient Name		Insurance Co				
Last Name			Group #			
First Name		Middle Initial				
Address		make State of the Land		by additional insurance?  Yes  No		
E-mail			Subscriber's Name			
City	THE PERSON SERVICES		Birthdate	SS#		
	4		Relationship to Pat	ient		
State	Zip		Insurance Co			
Sex M F Age			Group #			
Birthdate		and the second state of the second se	ASSIGNMENT AND			
☐ Married ☐ Widowed	☐ Single			d/or my dependent(s), have insurance coverage		
☐ Separated ☐ Divorced	☐ Partnered	for years		and assign direct		
Patient Employer/School			Name of I	nsurance Company(ies)		
	Signitification and I		Dr any otherwise paval	all insurance benote to me for services rendered. I understand that		
Occupation			financially responsible	for all charges whether or not paid by insurance. I aut		
Employer/School Address				re on all insurance submissions.		
				ntist may use my health care information and may di ne above-named Insurance Company(ies) and their a		
Employer/School Phone (	)		for the purpose of o	btaining payment for services and determining insuts payable for related services. This consent will end		
Spouse's Name				plan is completed or one year from the date signed b		
Birthdate						
			Signature of P	atient, Parent, Guardian or Personal Representative		
00"						
SS#						
SS#Spouse's Employer			Please print name	of Patient, Parent, Guardian or Personal Representat		
Spouse's Employer			Please print name	of Patient, Parent, Guardian or Personal Representat		
Spouse's EmployerWhom may we thank for referr	ring you?					
Spouse's Employer	ring you?					
Spouse's EmployerWhom may we thank for referr	ring you?			Relationship to Patient		
Spouse's Employer Whom may we thank for referr PHONE NU	ring you?		Date  Ext	Relationship to Patient  Cell Phone ()		
Spouse's Employer	MBERS	Work ()	Date  Ext	Relationship to Patient  Cell Phone ()		
Spouse's Employer	MBERS	Work ()  Best time and place to reach y someone who does not live in y	Date  Ext	Relationship to Patient  Cell Phone ()		
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PHONE NU  Spouse's Employer  Whom may we thank for referr  PHONE NU  Home ()  Spouse's Work ()  N CASE OF EMERGENCY, O  Name  Home Phone ()  DENTAL H  Reason for today's visit	IMBERS CONTACT (Specify	Work ()  Best time and place to reach y someone who does not live in y  Rela  Wor  Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smok Clicking or popping jaw	Date  Ext you our household.) ationship k Phone ()  Yes	Mouth breathing Yes Mouth pain, brushing Yes Orthodontic treatment Yes Pain around ear Yes		
PHONE NU  Spouse's Employer  PHONE NU  Home ()  Spouse's Work ()  N CASE OF EMERGENCY, O  Name  Home Phone ()  DENTAL H  Reason for today's visit	IMBERS CONTACT (Specify	Work ()	Date  Ext you our household.) ationship k Phone ()  Yes	Mouth breathing Yes Mouth pain, brushing Yes Orthodontic treatment Yes Periodontal treatment Yes Periodontal treatment Yes Periodontal treatment Yes C		
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PHONE NU  Spouse's Work ()  N CASE OF EMERGENCY, ON  Name  Home Phone ()  DENTAL H  Reason for today's visit  City/State  Date of last dental visit  Place a mark on "yes" or "no" have had any of the following:	INBERS CONTACT (Specify statements) ISTORY	Work ()  Best time and place to reach your someone who does not live in your someone who live in	Date  Ext you our household.) ationship ck Phone ()  Yes	Mouth breathing Yes Mouth pain, brushing Yes Orthodontic treatment Yes Periodontal treatment Yes Sensitivity to cold Sensitivity to sweets Yes Sensitivity to sweets		
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(Vers.D2SSS04)

Physician's Name				Date of last visit		
	he aroun of drugs or	ollectively referred to as "fer	-nhan?" These include co	mbinations of Ionimin, Adipex, Fa	etin /hran	nd
names of phentermine), Pond				mbinations of fortiffin, Adipex, Fa	istiii (bidi	10
Place a mark on "yes" or "no'	" to indicate if you ha	ave had any of the following				
AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	Yes	□N
nemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes	
arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes	
rtificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	Yes	
rtificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes	
sthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	Yes	
ack Problems	☐ Yes ☐ No	Hepatitis Type	Yes  No	Special Diet	Yes	
leeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	Yes	
lood Disease	□ Yes □ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	Yes	
ancer	☐ Yes ☐ No	Jaundice Jaundice	Yes No	Swollen Neck Glands	Yes	
hemical Dependency	☐ Yes ☐ No	Jaw Pain Kidney Disease	☐ Yes ☐ No	Thyroid Problems Tonsillitis	☐ Yes	
hemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes	
irculatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or	☐ Yes	
ongenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	neck	□ 103	
ortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	Yes	
ough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes	
iabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	Yes	
mphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No			
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	DICATION	5		ALLERGIES		
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