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# DENTAL REGISTRATION AND HISTORY

## 1) PATIENT INFORMATION

Date_____

Patient Name _____
(Last)

_____ _____
(First) (Middle Initial)

Soc. Sec. #_____

Address_____

City_____

State_____ Zip_____

E-mail_____

☐ Male ☐ Female Birthdate_____

☐ Married ☐ Single Age_____

Patient Employer/School_____

Occupation_____

Employer/School Address_____

_____

Employer/School Phone ( )_____

Spouse's Name _____

Birthdate _____

Soc. Sec. # _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

## 2) FINANCIAL/DENTAL INSURANCE

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.
Dr. Waring may use my health care information and may disclose such information to the below-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.

Who is responsible for this account? _____

Relationship to Patient _____

Soc. Sec. # _____ Birthdate _____

Insurance Co. _____

Group #_____

Subscriber's Employer and Address _____

_____

Is patient covered by additional insurance? ☐ Yes ☐ No

If yes, please complete:

Subscriber's Name _____

Soc. Sec. # _____ Birthdate _____

Relationship to Patient _____

Insurance Co._____

Group # _____

Subscriber's Employer and Address _____

_____

_____
(Signature of Patient, Parent, Guardian or Personal Representative)

_____
(Print name of Patient, Parent, Guardian or Personal Representative)

Date _____ Relationship to Patient_____

## 3) PHONE NUMBERS

Home ( )_____ Work ( )_____ Ext._____ Cell Phone ( )_____

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 ( )_____

## 4) DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State_____

Date of last dental visit_____

Date of last dental X-rays_____

Check the line to indicate if you have had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Bad breath | ___ | Fingernail biting | ___ | Mouth breathing | ___ |
| Bleeding gums | ___ | Food collection between teeth | ___ | Mouth pain, brushing | ___ |
| Blisters on lips or mouth | ___ | Grinding teeth | ___ | Orthodontic treatment | ___ |
| Burning sensation on tongue | ___ | Gums swollen or tender | ___ | Pain around ear | ___ |
| Chew on one side of mouth | ___ | Jaw pain or tiredness | ___ | Periodontal (gum) treatment | ___ |
| Cigarette, pipe, or cigar smoking | ___ | Lip or cheek biting | ___ | Sensitivity to cold | ___ |
| Clicking or popping jaw | ___ | Loose teeth or broken fillings | ___ | Sensitivity to heat | ___ |
| Dry mouth | ___ | | | Sensitivity to sweets | ___ |
| | | | | Sensitivity when biting | ___ |
| | | | | Sores or growths in your mouth | ___ |

How often do you floss?_____

How often do you brush?_____

## 5) HEALTH HISTORY

Physician's Name_____ Date of last visit _____

**Has your physician recommended that you take an antibiotic before dental treatment? Yes? _____ No? _____**

If yes, list medication _____ Reason_____

Check the line to indicate if you have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV | ___ | Epilepsy | ___ | Respiratory Disease | ___ | **Children:** | |
| Anemia | ___ | Fainting or dizziness | ___ | Rheumatic Fever | ___ | Unhappy dental experiences | |
| Arthritis, Rheumatism | ___ | Glaucoma | ___ | Scarlet Fever | ___ | _____ | |
| Artificial Heart Valves | ___ | Headaches | ___ | Shortness of Breath | ___ | Injuries to mouth, teeth, head | |
| Artificial Joints | ___ | Heart Murmur | ___ | Sinus Trouble | ___ | _____ | |
| Asthma | ___ | Heart Problems | ___ | Skin Rash | ___ | Mouth habits: thumb sucking, nail | |
| Back Problems | ___ | Hepatitis Type _____ | ___ | Special Diet | ___ | biting, mouth breathing, nursing | |
| Bleeding abnormally, | ___ | Herpes | ___ | Stroke | ___ | bottle habits, pacifier, etc. | |
| with extractions or surgery | | High Blood Pressure | ___ | Swollen Feet or Ankles | ___ | _____ | |
| Blood Disease | ___ | Jaundice | ___ | Swollen Neck Glands | ___ | Any speech problems | |
| Cancer | ___ | Jaw Pain | ___ | Thyroid Problems | ___ | _____ | |
| Chemical Dependency | ___ | Kidney Disease | ___ | Tonsillitis | ___ | Orthodontic appliances worn now | |
| Chemotherapy | ___ | Liver Disease | ___ | Tuberculosis | ___ | or ever been _____ | |
| Circulatory Problems | ___ | Low Blood Pressure | ___ | Tumor or growth on head or neck | ___ | Does your child brush teeth daily | |
| Congenital Heart Lesions | ___ | Mitral Valve Prolapse | ___ | Ulcer | ___ | _____ | |
| Cortisone Treatments | ___ | Nervous Problems | ___ | Venereal Disease | ___ | Do you assist child with tooth | |
| Cough, persistent or bloody | ___ | Pacemaker | ___ | Weight Loss, unexplained | ___ | brushing _____ | |
| Diabetes | ___ | Psychiatric Care | ___ | Accident involving head or | ___ | Is fluoride taken in any form_____ | |
| Emphysema | ___ | Radiation Treatment | ___ | neck injury | | _____ | |

Do you snore loudly? ☐ Yes ☐ No Has anyone observed you stop breathing during sleep? ☐ Yes ☐ No

Do you often feel tired, fatigued, or sleepy? ☐ Yes ☐ No Do you have or are you being treated for high blood pressure? ☐ Yes ☐ No

**Women:**

Are you pregnant? ☐ Yes ☐ No Due Date _____

Taking birth control pills? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

## 6) MEDICATIONS

**The medications that I am taking are**: (Please include all prescription, non-prescription, supplements and vitamins.)

_____ _____ _____

_____ _____ _____

Pharmacy Name _____ Phone ( )_____

## 7) ALLERGIES TO MEDICINES OR LATEX

Latex ___ Local Anesthetic ___ Penicillin ___

Other (please list) _____

_____