E. William Waring, Jr. D.D.S.
25 Center Square, New Oxford, PA 17350
717-624-2114

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) _____

_____