## **DENTAL REGISTRATION AND HISTORY**

PATIENT INI	FORMATI	ION	DENT	AL INSURANCE		
PATIENT INFORMATION DENTAL INSCRANCE						
Date	W	Who is responsible for this account?				
SS/HIC/Patient ID #		Re	elationship to Pati	atient		
Patient Name	In	Insurance Co.				
Last Name		G	Group #			
First Name		Middle Initial				
Address		7.51		d by additional insurance?  Yes  No		
E-mail			ubscriber's Name			
City		Bi	irthdate	e SS#		
	R	Relationship to Patient				
State	ZIP	In	Insurance Co			
Sex M F Age		G	Group #			
Birthdate			ASSIGNMENT AND RELEASE			
☐ Married ☐ Widowed ☐ Single ☐ Minor I certify that I, and/or my dependent(s), have insurance coverage with						
☐ Separated ☐ Divorced ☐ Partnered for years						
Patient Employer/School						
Occupation			Drall insurance benefits, if any, otherwise payable to me 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.			
Employer/School Address			The above-named dentist may use my health care information and may disclose			
		su	uch information to the	e above-named Insurance Company(i staining payment for services and de	es) and their agents	
Employer/School Phone ()		be	benefits or the benefits payable for related services. This consent will end when			
Spouse's Name my current treatment plan is completed or one year from the date signed belo						
Birthdate			Signature of Patient, Parent, Guardian or Personal Representative			
SS#		Signature of Patient, Parent, Guardian of Personal Representative				
Spouse's Employer Please print name of Patient, Parent, Guardian or Personal Representative						
Whom may we thank for referring you?						
Date Relationship to Patient						
PHONE NUMBERS						
Home ( )		Work ()	Ext	Cell Phone ()		
Spouse's Work () Best time and place to reach you						
Home Phone () Work Phone ()						
N WALTER & STATE	THO DAY					
DENTAL HIS	STORY					
Reason for today's visit		Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No	
		Chew on one side of mouth	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No	
Former Dentist		Cigarette, pipe, or cigar smoking Clicking or popping jaw	g ☐ Yes ☐ No	Orthodontic treatment Pain around ear	☐ Yes ☐ No	
City/State		Dry mouth	Yes No	Periodontal treatment	☐ Yes ☐ No	
		Fingernail biting	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No	
Date of last dental visit		Food collection between the teeth	h  Yes  No	Sensitivity to heat	☐ Yes ☐ No	
Date of last dental X-rays		Foreign objects	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No	
Place a mark on "yes" or "no" to indicate if you		Grinding teeth Gums swollen or tender	☐ Yes ☐ No	Sensitivity when biting Sores or growths in your mouth	☐ Yes ☐ No	
have had any of the following: Bad breath	☐ Yes ☐ No	Jaw pain or tiredness	Yes No			
Bleeding gums	☐ Yes ☐ No	Lip or cheek biting	☐ Yes ☐ No	How often do you floss?		
Blisters on lips or mouth	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No	How often do you brush?		