## **DENTAL REGISTRATION AND HISTORY**

PATIENT INFORMATI	ON .	DENT	AL INSURANCE	
4			ponsible for this account?	
Date				
SS/HIC/Patient ID #			ent	
Patient Name				
	Gr	oup #		
First Name	Middle Initial Is	patient covered b	y additional insurance? 🗌 Yes 🛛	No
Address	Su	bscriber's Name		
E-mail	Bir	thdate	SS#	
City	Re	lationship to Patie	ent	
State Zip	Supervision and the second second			
Sex 🗌 M 🔲 F Age				
Birthdate				
		SIGNMENT AND R certify that I, and	/or my dependent(s), have insuran	ce coverage with
	for years	Name of In	surance Company(ies)	assign directly to
Patient Employer/School				
	any		e to me for services rendered. I und	derstand that I am
Occupation	the		for all charges whether or not paid by in e on all insurance submissions.	surance. I authorize
Employer/School Address		e above-named den	tist may use my health care informatio	n and may disclose
	for		e above-named Insurance Company(ie taining payment for services and det	
Employer/School Phone ()	ber	nefits or the benefits	s payable for related services. This cor lan is completed or one year from the o	sent will end when
Spouse's Name		ourion rounion p		alle signed below.
Birthdate		Signature of Pa	tient, Parent, Guardian or Personal Rep	presentative
SS#			220million	
Spouse's Employer		Please print name o	of Patient, Parent, Guardian or Personal	Representative
Whom may we thank for referring you?		Date	Relationship to	o Patient
<b>PHONE NUMBERS</b>				
		E .	0	New York Come
Phone ()			Cell ()	
Spouse's Work () IN CASE OF EMERGENCY, CONTACT (Specify s				
Name			A CESCOL IN MILEO IN S	
Home Phone ()	Work F	Phone ()		
DENTAL HISTORY				
DENTAL HISTORY				
Reason for today's visit	Burning sensation on tongue	Yes No	Mouth breathing	Yes No
	Chew on one side of mouth		Mouth pain, brushing Orthodontic treatment	
Former Dentist	Cigarette, pipe, or cigar smoking Clicking or popping jaw	Yes No	Pain around ear	□ Yes □ No □ Yes □ No
City/State	Dry mouth		Periodontal treatment	
Date of last dental visit	Fingernail biting	Yes No	Sensitivity to cold	Yes No
Date of last dental X-rays	Food collection between the teeth		Sensitivity to heat	
Place a mark on "yes" or "no" to indicate if you	Foreign objects Grinding teeth	☐ Yes ☐ No ☐ Yes ☐ No	Sensitivity to sweets Sensitivity when biting	□ Yes □ No □ Yes □ No
have had any of the following:	Gums swollen or tender		Sores or growths in your mouth	Street of the second
Bad breath Yes No	Jaw pain or tiredness	Yes No	How often do you floss?	California -
Bleeding gums   Yes   No     Blisters on lips or mouth   Yes   No	Lip or cheek biting			
	Loose teeth or broken fillings	🗌 Yes 🔲 No	How often do you brush?	the second se

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hemia       Yes       No       Fainting or dizziness       Yes       No       Rheumatic Fever       Yes       No         thritis, Rheumatism       Yes       No       Glaucoma       Yes       No       Scarlet Fever       Yes       No         thritis, Rheumatism       Yes       No       Headaches       Yes       No       Scarlet Fever       Yes       No         thritis, Rheumatism       Yes       No       Headaches       Yes       No       Sinus Trouble       Yes       No         thritis, Rheumatism       Yes       No       Heart Murmur       Yes       No       Sinus Trouble       Yes       No         stima       Yes       No       Heart Murmur       Yes       No       Skin Rash       Yes       No         ack Problems       Yes       No       Heart Murmur       Yes       No       Skin Rash       Yes       No         ack Problems       Yes       No       Heart Murmur       Yes       No       Skin Rash       Yes       No         ack Problems       Yes       No       Heart Murmur       Yes       No       Skin Rash       Yes       No         acdord Prestore       Yes       No       Jaundice	HEALTH H	IISTORY_					
uppediation         year	Dhusiai min N				Date of last visit		
we you ever taken any of the group of drugs collectively referred to as "ner-pher?" These include combinations of lonimin, Adipex, Fastin (brand med of phetoermine), Pondimin (enfluramine). Wes		anhanata madiaatia	n2 Common brand names				
Immed of phentermine), Pondimin (lentiturantine) and Hedux (lexixenituration)_ the is into ace a mark on "yes" or "on "on to indicate it you have had any of the following:       Previous into ace in the following:       Previous into ace into						astin (brand	
DS/HIV       Yes       No       Epilepsy       Yes       No       Refurmatic       Prever       Yes       No         hemia       Yes       No       Galucoma       Yes       No       Scarlet Fever       Yes       No         thickil, Rheumatism       Yes       No       Heart Murmur       Yes       No       Scarlet Fever       Yes       No         thinkil, Rheumatism       Yes       No       Heart Murmur       Yes       No       Scarlet Fever       Yes       No         thinkil, Rheumatism       Yes       No       Heart Murmur       Yes       No       Scarlet Fever       Yes       No         thinking, Rheumatism       Yes       No       Heart Murmur       Yes       No       Scarlet Fever       Yes       No         act Problems       Yes       No       Heart Murmur       Yes       No       Scarlet Fever       Yes       No         act Problems       Yes       No       Heart Murmur       Yes       No       Scarlet Fever	names of phentermine), Pond	limin (fenfluramine)	and Redux (dextentiuramin				
DSH/IV       Pres       No       Epilepsy       Both       Rheumatic Fever       Yes       No         emia       Pres       No       Glaucoma       Pres       No       Starling or dizziness         thritis, Rheumatism       Pres       No       Headaches       Pres       No       Starling or dizziness         tificial Heart Valves       Pres       No       Headaches       Pres       No       Starling or dizziness         stima       Yes       No       Heart Mumur       Yes       No       Starling or dizziness         stima       Yes       No       Heart Mumur       Yes       No       Starling or dizzines         stima       Yes       No       Heart Mumur       Yes       No       Starling or dizzines         startactions or surgery       High Blood Pressure       Yes       No       Starling or dizzines       Yes       No         oader       Peis       No       Jaurdice       Yes       No       Stroke       Yes       No         aner       Yes       No       Kidney Disease       Yes       No       Swollen Feet or Ankles       Yes       No         codd Disease       Yes       No       Liver Disease       Yes <t< td=""><td>Place a mark on "yes" or "no"</td><td></td><td></td><td></td><td>Rospiratory Disago</td><td></td></t<>	Place a mark on "yes" or "no"				Rospiratory Disago		
Infers       No       Tailing of dizzless       No       Scalet Fever       Yes       No         Inficial Heart Valves       Yes       No       HeatAches       Yes       No       Shortness of Breath       Yes       No         stind       Yes       No       Heat Murmur       Yes       No       Shortness of Breath       Yes       No         stind       Yes       No       Heart Murmur       Yes       No       Skin Rash       Yes       No         ack Problems       Yes       No       Heart Murmur       Yes       No       Skin Rash       Yes       No         ack Problems       Yes       No       Heart Murmur       Yes       No       Skin Rash       Yes       No         actor       Heart Stock       Heart Stock       Yes       No       Special Diet       Yes       No         aneer       Yes       No       Kidney Dieease       Yes       No       Swollen Feet or Ankles       Yes       No         aneer       Yes       No       Kidney Dieease       Yes       No       Swollen Feet or Ankles       Yes       No         ander Pysis       No       Kidney Dieease       Yes       No       Tworolibrois <t< td=""><td>AIDS/HIV</td><td></td><td></td><td></td><td></td><td></td></t<>	AIDS/HIV						
Initial, minuturiatili       Inso       Into       <	Anemia		Fainting or dizziness				
Initial iterat varies       Ites       Ites <t< td=""><td>Arthritis, Rheumatism</td><td></td><td>Glaucoma</td><td></td><td></td><td>🗆 Yes 🗌 No</td></t<>	Arthritis, Rheumatism		Glaucoma			🗆 Yes 🗌 No	
Index Normal       Index Normal <td< td=""><td>Artificial Heart Valves</td><td>Yes No</td><td>Headaches</td><td></td><td></td><td>Yes No</td></td<>	Artificial Heart Valves	Yes No	Headaches			Yes No	
and Problems       No       Hepatitis Type       Yes       No       Sleep apnea       Yes       No         eeding abnormally, with       Yes       No       Herpes       Yes       No       CPAP Machine       Yes       No         eading abnormally, with       Yes       No       Herpes       Yes       No       CPAP Machine       Yes       No         odd Disease       Yes       No       Jaundice       Yes       No       Special Diet       Yes       No         ancer       Yes       No       Jaundice       Yes       No       Swollen Feet or Ankles       Yes       No         hemical Dependency       Yes       No       Law Pain       Yes       No       Swollen Neck Clands       Yes       No         irculatory Problems       Yes       No       Low Diood Pressure       Yes       No       Tuberculosis       Yes       No         ordshore Treatments       Yes       No       Mitral Valve Prolapse       Yes       No       Tuberculosis       Yes       No         updth, persistent or blody       Yes       No       Meryous Problems       Yes       No       Tuberculosis       Yes       No         updth, persistent or blody       Yes </td <td>Artificial Joints</td> <td>🗌 Yes 🗌 No</td> <td>Heart Murmur</td> <td>🗌 Yes 📃 No</td> <td></td> <td>🗆 Yes 🗌 No</td>	Artificial Joints	🗌 Yes 🗌 No	Heart Murmur	🗌 Yes 📃 No		🗆 Yes 🗌 No	
eeding abnormally, with       Yes       No       Herpes       Yes       No       Special Diet       Yes       No         extractions or surgery       High Blood Pressure       Yes       No       Special Diet       Yes       No         ancer       Yes       No       Jaw Pain       Yes       No       Stroke       Yes       No         hemical Dependency       Yes       No       Kidney Disease       Yes       No       Swollen Neek Glands       Yes       No         hemical Dependency       Yes       No       Liver Disease       Yes       No       Thyroid Problems       Yes       No         irculatory Problems       Yes       No       Mitral Valve Prolapse       Yes       No       Tumor or growth on head or       Yes       No         ongenital Heart Lesions       Yes       No       No       No       Tumor or growth on head or       Yes       No         ongenital Heart Lesions       Yes       No       No       No       Tumor or growth on head or       Yes       No         ongenital Heart Lesions       No       Nervous Problems       Yes       No       Tumor or growth on head or       Yes       No         output persistent or bloody       Yes       N	Asthma	Yes No	Heart Problems	🗌 Yes 🗌 No		Yes No	
extractions or surgery       High Blood Pressure       Yes       No       Special Diet       Yes       No         odd Disease       Yes       No       Jaundice       Yes       No       Stroke       Yes       No         ancer       Yes       No       Jaundice       Yes       No       Swollen Feet or Ankles       Yes       No         hemical Dependency       Yes       No       Liver Disease       Yes       No       Swollen Neck Glands       Yes       No         hemotherapy       Yes       No       Liver Disease       Yes       No       Thyroid Problems       Yes       No         orgenital Heart Lesions       Yes       No       Liver Disease       Yes       No       Tuberculosis       Yes       No         orgenital Heart Lesions       Yes       No       Mitral Valve Prolapse       Yes       No       Tuberculosis       Yes       No         orgenital Heart Lesions       Yes       No       Pacemaker       Yes       No       Tuberculosis       Yes       No         orgenital Heart Lesions       Yes       No       Pacemaker       Yes       No       Tuberculosis       Yes       No         oupdt, persisitent or bloody       Yes	Back Problems	Yes No	Hepatitis Type	Yes No	Sleep apnea	🗌 Yes 🗌 No	
load Disease        Yes       No       Jaundice        Yes       No       Stroke        Yes       No         ancer        Yes       No       Jaundice        Yes       No       Stroke        Yes       No         hemical Dependency        Yes       No       Jaundice        Yes       No       Swollen Peet or Ankles        Yes       No         hemical Dependency        Yes       No       Kidney Disease        Yes       No       Swollen Neck Glands        Yes       No         iroulatory Problems        Yes       No       Low Blood Pressure        Yes       No       Thyroid Problems        Yes       No         orgenital Heart Lesions        Yes       No       Mitral Valve Prolapse        Yes       No       Tumor or growth on head or        Yes       No         orgenital Heart Lesions        Yes       No       Pacemaker        Yes       No       Tumor or growth on head or        Yes       No         ough, persistent or bloody       Yes       No       Pacemaker        Yes       No       Ulcer        Yes       No         mapproximation       Yes       No       Radiation Treatment        Yes       No       Venereal Disease        Yes       No	Bleeding abnormally, with	🗌 Yes 🗌 No	Herpes	🗌 Yes 🔲 No	CPAP Machine	🗌 Yes 🗌 No	
ancer       \ranket	extractions or surgery		High Blood Pressure	🗌 Yes 🗌 No	Special Diet	Yes No	
hemical Dependency       Yes       No       Kidney Disease       Yes       No       Swollen Neck Glands       Yes       No         hemotherapy       Yes       No       Liver Disease       Yes       No       Thyroid Problems       Yes       No         orgenital Heart Lesions       Yes       No       Liver Disease       Yes       No       Thyroid Problems       Yes       No         orgenital Heart Lesions       Yes       No       Metrod Pressure       Yes       No       Tomoid or or solutions       Yes       No         orgenital Heart Lesions       Yes       No       Nervous Problems       Yes       No       Tumor or growth on head or       Yes       No         orgenital Heart Lesions       Yes       No       Pacemaker       Yes       No       Tumor or growth on head or       Yes       No         orgenital Heart Lesions       Yes       No       Pacemaker       Yes       No       Networks       No         ough, persistent or bloody       Yes       No       Pacemaker       Yes       No       Ulcer       Yes       No         o you wear contact lenses?       Yes       No       Pacemaker       Yes       No       Venereal Disease       Yes       No	Blood Disease	Yes No	Jaundice	🗌 Yes 🔲 No	Stroke	Yes No	
hemical Dependency       \rightarrow \	Cancer	Yes No	Jaw Pain	🗌 Yes 🔲 No	Swollen Feet or Ankles		
hemotherapy Ves No Liver Disease Yes No Thyroid Problems Ves No   irculatory Problems Ves No Low Blood Pressure No Tonsilitiis Yes No   ongenital Heart Lesions Ves No Mitral Valve Prolapse Yes No Tuberculosis Yes No   ordisone Treatments Ves No Nervous Problems Yes No Tuberculosis Yes No   ough, persistent or bloody Yes No Pacemaker Yes No numor or growth on head or Yes No   iabetes Yes No Pacemaker Yes No numor or growth on head or Yes No   iabetes Yes No Pacemaker Yes No Nervous Problems Yes No numor or growth on head or Yes No   iabetes Yes No Pacemaker Yes No No numor or growth on head or Yes No   iabetes Yes No Pacemaker Yes No Ulcer Yes No   mphysema Yes No Radiation Treatment Yes No Weight Loss, unexplained Yes No   former: Are you pregnant? Yes No Ne Are you nursing? Yes No   agnosis: Imamacy Name Imamacy Name Imamacy Imamacy Imamacy Imamacy   harmacy Name Imamacy Imate Internet to Internet to Internet to Internet t	Chemical Dependency	Yes No	Kidney Disease	Yes No	Swollen Neck Glands		
irculatory Problems       Yes       No       Low Blood Pressure       Yes       No       Tonsilitis       Yes       No         orgenital Heart Lesions       Yes       No       Mitral Valve Prolapse       Yes       No       Tuberculosis       Yes       No         ordisone Treatments       Yes       No       Nervous Problems       Yes       No       Tumor or growth on head or       Yes       No         iabeles       Yes       No       Pacemaker       Yes       No       neck       No         iabeles       Yes       No       Pacemaker       Yes       No       neck       No         iabeles       Yes       No       Pacemaker       Yes       No       Neck       No         oy ou wear contact lenses?       Yes       No       Radiation Treatment       Yes       No       Weight Loss, unexplained       Yes       No         oy ou wear contact lenses?       Yes       No       Due date       Are you nursing?       Yes       No         Taking birth control pills?       Yes       No       Aspirin       Local Anesthetic         agnosis:	Chemotherapy	Yes No	Liver Disease	Yes No	Thyroid Problems		
ongenital Heart Lesions \rightarrow Ks \No Mitral Valve Prolapse \rightarrow Ks	Circulatory Problems	Yes No	Low Blood Pressure				
ortisone Treatments Yes No Nervous Problems Yes No Tumor or growth on head or Yes No   ough, persistent or bloody Yes No Pacemaker Yes No neck   jabetes Yes No Psychiatric Care Yes No Ulcer Yes No   mphysema Yes No Radiation Treatment Yes No Venereal Disease Yes No   o you wear contact lenses? Yes No Due date Are you nursing? Yes No   Are you pregnant? Yes No Due date Are you nursing? Yes No   agnosis: No Due date Aspirin Local Anesthetic   agnosis: Barbiturates (Sleeping pills) Penicillin   harmacy Name Latex Latex   was there been any change in your health since your last dental appointment? Yes No	Congenital Heart Lesions	Yes No					
ough, persistent or bloody   Yes No Pacemaker   Yes No neck   iabetes   Yes No Psychiatric Care   Yes No Ulcer   Yes No   mphysema   Yes No Radiation Treatment   Yes No Venereal Disease   Yes No   o you wear contact lenses?   Yes No Due date Are you nursing?   Yes No   Are you pregnant?   Yes No Due date Are you nursing?   Yes No   MEDICATIONS ALLERGIES   st any medications you are currently taking and the correlating agnosis:   Aspirin   Local Anesthetic   agnosis:   Barbiturates (Sleeping pills)   Penicillin   indent   Odine   Other   harmacy Name   Latex   has there been any change in your health since your last dental appointment?   Yes   No	Cortisone Treatments	Yes No					
iabetes  Yes No Psychiatric Care  Yes No Ulcer  Yes No   mphysema  Yes No Radiation Treatment  Yes No Venereal Disease  Yes No   o you wear contact lenses?  Yes No Due date Are you nursing?  Yes No   Are you pregnant?  Yes No Due date Are you nursing?  Yes No   Taking birth control pills? Yes No No No Yes No   MEDICATIONS ALLERGIES   st any medications you are currently taking and the correlating agnosis:   Aspirin   Local Anesthetic   agnosis:   Barbiturates (Sleeping pills)   Penicillin   harmacy Name   Iodine   Other   hone ()   Latex	Cough, persistent or bloody	Yes No			and the second se		
mphysema Yes No Radiation Treatment Yes No Venereal Disease Yes No   o you wear contact lenses? Yes No Weight Loss, unexplained Yes No   ormen: Are you pregnant? Yes No Weight Loss, unexplained Yes No   Taking birth control pills? Yes No No Are you nursing? Yes No   MEDICATIONS ALLERGIES   st any medications you are currently taking and the correlating agnosis: Aspirin Local Anesthetic   agnosis: Barbiturates (Sleeping pills) Penicillin   harmacy Name Iodine Other   hone () Latex	Diabetes	☐ Yes ☐ No					
Induction meathem   Intervention meathem   Intervention meathem   Are you pregnant?   Yes   No   Due date   Are you pregnant?   Yes   No   Taking birth control pills?   Yes   No   Due date   Are you nursing?   Yes   No   MEDICATIONS   Allergies   MEDICATIONS   Allergies   Methematications you are currently taking and the correlating agnosis:   Barbiturates (Steeping pills)   Barbiturates (Steeping pills)   Penicillin   Codeine   Sulta   Indiance   Indiance   Indiance   Definition   Indiance   Indine   Indian					01001		
Are you pregnant? Yes No   Due date Are you nursing? Yes   Taking birth control pills? Yes No     MEDICATIONS ALLERGIES     agnosis: Aspirin   agnosis: Barbiturates (Sleeping pills)   Barbiturates (Sleeping pills) Penicillin   Codeine Sulfa   I lodine Other     Latex Latex        UPDATES (To be filled in at future appointments)     Has there been any change in your health since your last dental appointment?			Radiation freatment				
Are you pregnant? Yes No   Taking birth control pills? Yes No   MEDICATIONS   ALLERGIES   agnosis:					weight Loss, unexplained		
Taking birth control pills?       Yes       No         MEDICATIONS       ALLERGIES         st any medications you are currently taking and the correlating agnosis:			Due date	Are you pu			
MEDICATIONS       ALLERGIES         st any medications you are currently taking and the correlating agnosis:							
st any medications you are currently taking and the correlating agnosis:     Barbiturates (Sleeping pills)     Penicillin     Codeine   Sulfa   Icotal Anesthetic     Barbiturates (Sleeping pills)   Penicillin   Codeine   Sulfa   Icotal Anesthetic     Barbiturates (Sleeping pills)        Penicillin   Codeine   Icotal Anesthetic        Codeine   Icotal Anesthetic           Icotal Anesthetic              Icotal Anesthetic							
agnosis:	MEDICATIONS			ALLERGIES			
Barbiturates (Sleeping pills)  Penicillin      Barbiturates (Sleeping pills)  Penicillin      Codeine      Judine      Latex   UPDATES (To be filled in at future appointments)  Has there been any change in your health since your last dental appointment?  Yes No	List any medications you are currently taking and the correlating diagnosis:			Aspirin Local Anesthetic			
harmacy Name   lodine hone () Latex UPDATES (To be filled in at future appointments) Has there been any change in your health since your last dental appointment? Yes No				Barbiturates (Sleeping pills)			
Image: name					□ Sulfa		
Image: Description of the system	Pharmacy Name			Iodine     Other			
Has there been any change in your health since your last dental appointment? Yes No	Phone ()		Latex				
Has there been any change in your health since your last dental appointment? Yes No							
	UPDATES	(To be filled in	at future appointme	nts)			
	Has there been any	y change in your he	alth since your last dental a	appointment?  Yes	No		
re you taking any new medications? If so, what?							
	Patient's Signature						

Date

Date \_

Date \_

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D . . . .

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Doctor's Signature

Has there been any change in your health since your last dental appointment? Yes No

For what conditions?

Are you taking any new medications? \_\_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature

Doctor's Signature