DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date: _____ SSN: _____
Patient Name: _____, _____ ____
Last First MI
Address: _____
_____
Sex: ☐Male ☐Female Age: _____
Birth Date:_____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years
Spouse's Name_____
Spouse's Birth Date _____
Spouse's SSN _____
Spouse's Employer _____

Patient Employer / School _____
Occupation _____
Employer/ School Address_____
_____
Employer/ School Phone(_____) _____

2 DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to Patient_____
Insurance Company _____
Group # _____
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name _____
Birth Date _____ SSN# _____
Relationship to Patient_____
Insurance Company _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____ _____ and I assign directly to Garden City Dental Center all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my signature on all insurance submissions.

_____ _____
Patient's Signature Date
Relationship to patient _____

3 PHONE NUMBERS

Home (_____) _____ Work (_____)_____ Cell (_____) _____
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-Ray _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐Yes	☐ No
Bleeding	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No
Fingernail Biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign Object	☐ Yes	☐ No
Grinding Teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No

5 HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS / HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis / Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type ____	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Feet/ Ankles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor or growth on head or neck.	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No		
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No			Weight Loss, unexplained	☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due Date: _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATION

List any medication you are currently taking and the correlating diagnosis:_____

_____

Pharmacy Name: _____

Pharmacy Phone (____)_____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbituratos (Sleeping Pills) ☐ Penicillin

☐ Codiene ☐ Sulfa

☐ Iodine ☐ Latex

☐ Other _____

By way of my signature, I affirm all information above is true and correct to the best of my knowledge. I understand that it is my responsibility to provide Garden City Dental Center with any changes to my personal and/ or medical history.

_____ _____

Patient's Signature Date

6 HIPPA

I have read the Privacy Notice and understand my rights contained in the notice.

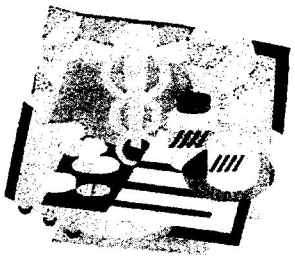
By way of my signature, I provide Garden City Dental Center with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ _____

Patient's Name (Print) Date

_____ _____

Patient's Signature Date



Date:_____

Patient Name:_____

Date of Birth:_____ Chart Number:_____

Medication List

Prescriptions

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Vitamins / Minerals

1. _____
2. _____
3. _____
4. _____
5. _____

Other

_____

_____

_____

Patient Signature: _____

Assistant: _____