

# DENTAL REGISTRATION AND HISTORY

## 1

### PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

\_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2

### DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_



## 3

### PHONE NUMBERS

Phone (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ 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 _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	



# HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.  Yes  No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

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

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

## MEDICATIONS

## ALLERGIES

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            |
| <input type="checkbox"/> Iodine                        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Latex                         | _____                                     |

### AUTHORIZATION FOR RELEASE OF INFORMATION

Dr. Michael Edenfield's office is authorized to release information for appointment reminders, x-rays, treatment and finances via...

**CIRCLE ALL THE APPLY VOICEMAIL EMAIL TEXT**

I also authorize ONLY the following person or persons to discuss information concerning appointments, medical concerns, x-ray result, and finances:

Authorized Person \_\_\_\_\_ Phone# \_\_\_\_\_

Authorized Person \_\_\_\_\_ Phone# \_\_\_\_\_

I have read/ received a copy of our practice's **FINANCIAL POLICY AND NOTICES OF PRIVACY PRACTICES** and hereby give consent for its use and disclosure of health information to provide treatment, payment and health care operations

Signature \_\_\_\_\_

Date \_\_\_\_\_