DENTAL PROFESSIONALS P.L.C.

REGISTRATION HISTORY

Welcome…

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT HISTORY

Today's Date: _____
Name: _____
Last First MI Mr. Mrs. Ms. Dr.
I prefer to be called: _____ Male Female
Birth Date: ____/____/____ Age: _____
SS#: _____
Home Address: _____
_____
E-mail Address: _____
Single Married Divorced Widowed Separated
Home #: (_____) _____
Work #: (_____) _____
Cell #: (_____) _____
Employer: _____
Employer's Address: _____
How long there? _____
Occupation: _____
If a student, what college do you attend?: _____
Best times to reach you? When: _____
Whom may we thank for referring you?: _____

PARENT'S, GUARDIAN OR SPOUSE

Mother's Name or Guardian: _____
Address: _____
Employer: _____
Work #: (_____) _____
Cell #: (_____) _____
E-mail: _____
SS #:_____ Birthdate: _____/_____/_____

Father's Name: _____
Address: _____
Employer: _____
Work #: (_____) _____
Cell #: (_____) _____
E-mail: _____
SS #:_____ Birthdate: _____/_____/_____

Spouse's Name: _____
Employer: _____
Work #: (_____) _____
Cell #: _____
E-mail: _____
SS #: _____
Birth Date: _____/_____/_____

DENTAL INSURANCE

Insurance Co. Name: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____
Group or Policy #: _____
Insured's Name: _____
Relationship: _____
Insured Birthdate: _____/_____/_____
Insured SS #: _____
Insured Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: (_____) _____
Group or Policy #: _____
Insured Name: _____
Relationship: _____
Insured's Birthdate: _____/_____/_____
Insured SS #: _____
Insured Employer: _____

Payment is due in full at the time of treatment unless prior arrangements have been made and approved. You alone, not your insurance company, are responsible for payment of your account. Statements are mailed the first day of each month. All accounts are due by the 10th of each month. All past due accounts are subject to a 1 ½% per month late charge (18% annual). Unpaid accounts 60 days old will be subject to Small Claims proceedings.

X_____
Signature Date

How do you plan to pay for today's visit? Cash Check
Credit Card

EMERGENCIES

In the event of an emergency, is there someone who lives near you that we should contact?
His / Her Name: _____
Relationship: _____
Work #: (_____) _____
Home #: (_____) _____
Cell #: (_____) _____

MEDICAL HISTORY

PATIENT: _____

Do you have a personal physician? Yes No
Physician's Name: _____
Phone #: (_____) _____
Date of last visit: _____
Are you allergic to or have you had a reaction to?:

Y	N	Local Anesthetics	Y	N	Latex
Y	N	Aspirin	Y	N	Sulfa Drugs
Y	N	Penicillin/Antibiotics	Y	N	Codeine
Y	N	Barbiturates/sedatives			

Other: _____
Your current physical health is: Good Fair Poor
Are you currently under the care of a physician? Y N
Please Explain: _____
Are you currently taking any prescription / over the counter drugs? Yes No
Please list: _____
_____
Do you smoke or use tobacco in any form? Yes No
Are you alcohol or drug dependent? Yes No
If yes, have you received treatment? Yes No
For women:
Are you taking birth control pills? Yes No
Are you pregnant? Yes No

HEALTH RISK FACTORS

Y	N	Unsure	Anemia
Y	N	Unsure	Artificial Bones / Joints
Y	N	Unsure	Artificial Valves
Y	N	Unsure	Asthma
Y	N	Unsure	Arthritis
Y	N	Unsure	Blood Transfusion / Disorders
Y	N	Unsure	Cancer / Chemotherapy
Y	N	Unsure	Radiation Treatment
Y	N	Unsure	Diabetes
Y	N	Unsure	Tuberculosis (TB)
Y	N	Unsure	Difficulty Breathing/COPD
Y	N	Unsure	Drug / Alcohol Abuse
Y	N	Unsure	Emphysema
Y	N	Unsure	Glaucoma
Y	N	Unsure	Epilepsy / Seizures / Fainting Spells
Y	N	Unsure	Fever Blisters / Herpes
Y	N	Unsure	Stroke
Y	N	Unsure	Congenital Heart Defect
Y	N	Unsure	Heart Attack
Y	N	Unsure	Heart Murmur
Y	N	Unsure	Heart Surgery / Pacemaker
Y	N	Unsure	Hemophilia / Abnormal Bleeding
Y	N	Unsure	Hepatitis
Y	N	Unsure	High / Low Blood Pressure
Y	N	Unsure	HIV + / AIDS
Y	N	Unsure	Kidney Problems
Y	N	Unsure	Psychiatric Problems
Y	N	Unsure	Rheumatic / Scarlet Fever
Y	N	Unsure	Shingles
Y	N	Unsure	Mitral Valve Prolapse
Y	N	Unsure	Aspirin
Y	N	Unsure	Bone Density Medications
Y	N	Unsure	Vision Problems
Y	N	Unsure	Hearing Problems

DENTAL HISTORY

Why have you come to the dentist today?
_____
_____
Previous / Present Dentist: _____
Date of last dental visit: _____
Date of last X-rays: _____
Has a physician or previous dentist recommended you take antibiotics prior to dental treatment? Yes No
Are you currently in pain? Yes No
Have you ever had a serious / difficult problem associated with any previous dental work? Yes No
If yes, explain: _____
Your current dental health is: Good Fair Bad
Do you like your smile? Yes No
If no, what don't you like?: _____
Do your gums ever bleed? Yes No
Have you had any periodontal (gum) treatments? Y N
Have you ever had braces? Yes No
Do you wear removable dental appliances? Yes No
How many times a week do you floss? _____
How many times a day do you brush your teeth? _____

CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I hereby authorize payment directly to the Dental Professionals, P.L.C. office of the group insurance benefits otherwise payable to me.

X_____
Signature Date

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.