

## DENTAL REGISTRATION AND HISTORY

Date: \_\_\_\_\_

## PATIENT INFORMATION

Name: \_\_\_\_\_

| Last | First | MI |
|------|-------|----|
|------|-------|----|

Address: \_\_\_\_\_

City: \_\_\_\_\_

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

SSN: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

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

Work Phone: ( ) Cell Phone: ( )

Sex: ☐ M ☐ F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_☐ Married      ☐ Widowed      ☐ Single      ☐ Minor☐ Separated      ☐ Divorced      ☐ Partnered

Occupation: \_\_\_\_\_

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

Birthdate: \_\_\_\_\_

Spouse's E-mail: \_\_\_\_\_

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

SSN: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Work Phone: ( ) Cell Phone: ( )

Whom may we thank for referring you?

**Thank you for trusting us with your healthcare. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.**

## DENTAL INSURANCE

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

Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: ID#:

Employer: \_\_\_\_\_

Insurance Co.:

Group #: \_\_\_\_\_ Phone: (       ) \_\_\_\_\_

Does patient have secondary coverage? ☐ Yes ☐ No

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

Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_ ID#: \_\_\_\_\_

Employer: \_\_\_\_\_

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

Group #: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Insurance Agreement: I certify that I and/or my dependents have insurance coverage with \_\_\_\_\_  
Name of Insurance Company

and assign directly to Dr. Brice all 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. Any benefit coverage quoted is an estimate based on the most current information available to us. Billing and/or interest charges are applied to balances over 30 days (rate of 1.56% or min. \$1.00 authorize the use of my signatures on all insurance submissions. Dr. Brice may use health care information and may disclose such information to the above-named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services.

### ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Brice's Notice of Privacy Practices.

X: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient, Parent or Guardian

# Medical History

PATIENT NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No \_\_\_\_\_  
Do you use tobacco? ☐ Yes ☐ No  
Do you use controlled substances? ☐ Yes ☐ No

Women: Are you \_\_\_\_\_  
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? \_\_\_\_\_  
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs  
☐ Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following? \_\_\_\_\_

|                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine        | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia            | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments       | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease       | <input type="radio"/> Yes <input type="radio"/> No | Diabetes                  | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A           | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss         | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis               | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction            | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C      | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis             | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia                    | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded             | <input type="radio"/> Yes <input type="radio"/> No | Herpes                | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever            | <input type="radio"/> Yes <input type="radio"/> No |
| Angina                    | <input type="radio"/> Yes <input type="radio"/> No | Emphysema                 | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure   | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism                 | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout            | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures      | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol      | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever              | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve    | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding        | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash         | <input type="radio"/> Yes <input type="radio"/> No | Shingles                   | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint          | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst          | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia          | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease        | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma                    | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat   | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble              | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease             | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough            | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems       | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida               | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea         | <input type="radio"/> Yes <input type="radio"/> No | Leukemia              | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches        | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease         | <input type="radio"/> Yes <input type="radio"/> No | Stroke                     | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily             | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes            | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure    | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs          | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer                    | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma                  | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease          | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease            | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy              | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever                 | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis                | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains               | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure      | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis          | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis               | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur              | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints    | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths          | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker           | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease   | <input type="radio"/> Yes <input type="radio"/> No | Ulcers                     | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions               | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease     | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care      | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease           | <input type="radio"/> Yes <input type="radio"/> No |
|                           |  |                           |  |                       |  | Yellow Jaundice            | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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X: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient, Parent or Guardian: \_\_\_\_\_