

Welcome to
our practice!

DENTAL REGISTRATION



Date: / /

PATIENT DEMOGRAPHICS

PATIENT NAME Last:		First:		MI:
SSN:		Medicare #:		
Address:				
City:		State:	Zip Code:	
Home Phone:		Work Phone:	Cell Phone:	
Email:			Birth Date:	
Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed			Sex: <input type="radio"/> Male <input type="radio"/> Female	
Patient Employer:				
Employer Address:				
City:		State:	Zip Code:	
Employer Phone:		Occupation:		
Spouse Name:		Birth Date:	SSN:	
Spouse Employer:		Spouse Work Phone:		
EMERGENCY CONTACT Name:		Relationship to Patient:		
Home Phone:		Work Phone:	Cell Phone:	
Whom can we thank for referring you?				

DENTAL INSURANCE

RESPONSIBLE PARTY NAME Last:		First:		MI:
Relationship to Patient:		Birth Date:	SSN:	
Insurance Company:			Group #:	
ADDITIONAL INSURANCE <input type="checkbox"/> N/A Last:		First:		MI:
Relationship to Patient:		Birth Date:	SSN:	
Insurance Company:			Group #:	

I certify that I and/or my dependents, have insurance coverage with _____ and assign directly to Dr. Bonnie M. Hiers 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. I authorize the use of my signature on all insurance submissions.

Dr. Bonnie M. Hiers may use my healthcare information and may disclose such information to the above-mentioned insurance company/ companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature (Patient/Parent/Guarantor/Personal Representative)

Date

Print Name (Patient/Parent/Guarantor/Personal Representative)

Relationship to patient

Payment is due in full at the time of treatment unless prior arrangements have been approved.

DENTAL HISTORY

Reason for today's visit:				
Date of last dental visit:		Date of last dental X-rays:		
I brush my teeth _____ times per <input type="radio"/> day <input type="radio"/> week <input type="radio"/> month		I floss my teeth _____ times per <input type="radio"/> day <input type="radio"/> week <input type="radio"/> month		
FORMER DENTIST Last:		First:		MI:
City:		State:	Zip Code:	

- OVER -

DENTAL HISTORY (continued)

(Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Fingernail biting | <input type="checkbox"/> Pain around ear |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Blisters on lips or mouth | <input type="checkbox"/> Grinding/clenching teeth | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Broken fillings | <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Burning sensation on tongue | <input type="checkbox"/> Jaw pain/tiredness | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Chewing on one side of mouth | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Sensitivity when brushing |
| <input type="checkbox"/> Cigarette, pipe or cigar smoking | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Sores or growth in mouth |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Other: _____ |

MEDICAL HISTORY

PHYSICIAN	Name:	Phone:	Last visited on:						
	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">No <input type="checkbox"/></td> <td style="width: 50%;">Yes <input type="checkbox"/></td> </tr> </table>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">No <input type="checkbox"/></td> <td style="width: 50%;">Yes <input type="checkbox"/></td> </tr> </table>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">No <input type="checkbox"/></td> <td style="width: 50%;">Yes <input type="checkbox"/></td> </tr> </table>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
No <input type="checkbox"/>	Yes <input type="checkbox"/>								
No <input type="checkbox"/>	Yes <input type="checkbox"/>								
No <input type="checkbox"/>	Yes <input type="checkbox"/>								
	<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis, Rheumatism <input type="checkbox"/> Artificial Heart Valves <input type="checkbox"/> Artificial joints <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Disease <input type="checkbox"/> Bleeding, excessive <input type="checkbox"/> Bulimia <input type="checkbox"/> Cardiac Implant <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Cortisone Treatments <input type="checkbox"/> Cough, persistent <input type="checkbox"/> Diabetes <input type="checkbox"/> Pregnant? If Yes, Due Date: _____	<input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fainting/dizziness <input type="checkbox"/> Glaucoma <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Problems <input type="checkbox"/> Hepatitis type: _____ <input type="checkbox"/> Herpes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Jaundice <input type="checkbox"/> Jaw pain <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Nervous Problems <input type="checkbox"/> Pacemaker Women Only <input type="checkbox"/> Are you nursing?	<input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Skin Rash <input type="checkbox"/> Special Diet <input type="checkbox"/> Stroke <input type="checkbox"/> Swollen Feet/Ankles <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tumor or growth in head/neck <input type="checkbox"/> Ulcer <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Wear contact lenses <input type="checkbox"/> Weight Loss, unexplained <input type="checkbox"/> Taking Birth Control pills?						

MEDICATIONS

Medication	Reason	Medication	Reason
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Pharmacy Name: _____ Phone Number: _____

ALLERGIES

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

MEDICAL HISTORY UPDATES

(for office use)

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