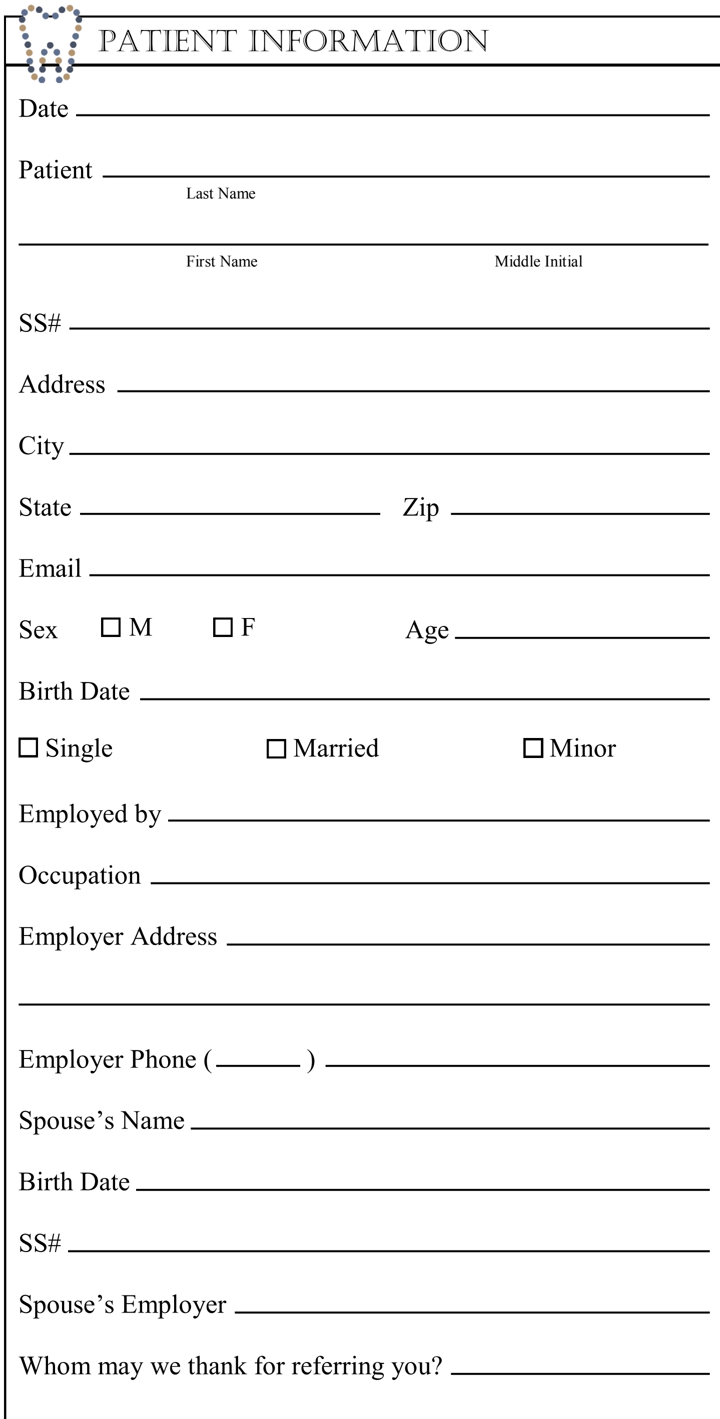
Dental Registration and History

Brett H. Taylor, D.D.S.



PATIENT INFORMATION

Date ______

Patient ______
Last Name

______
First Name Middle Initial

SS# ______

Address ______

City ______

State ______ Zip ______

Email ______

Sex ☐ M ☐ F Age ______

Birth Date ______

☐ Single ☐ Married ☐ Minor

Employed by ______

Occupation ______

Employer Address ______

______

Employer Phone (____) ______

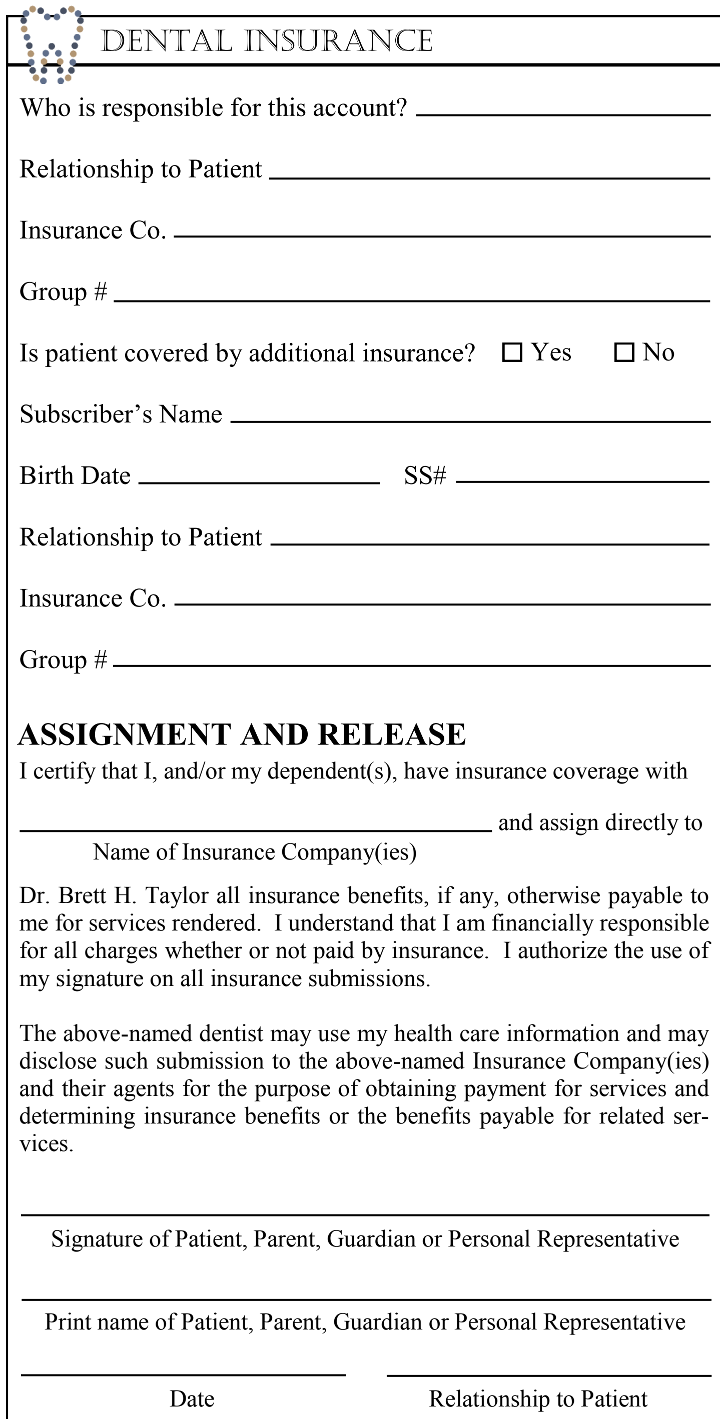
Spouse's Name ______

Birth Date ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______



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 ______

Birth Date ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

______ and assign directly to
Name of Insurance Company(ies)

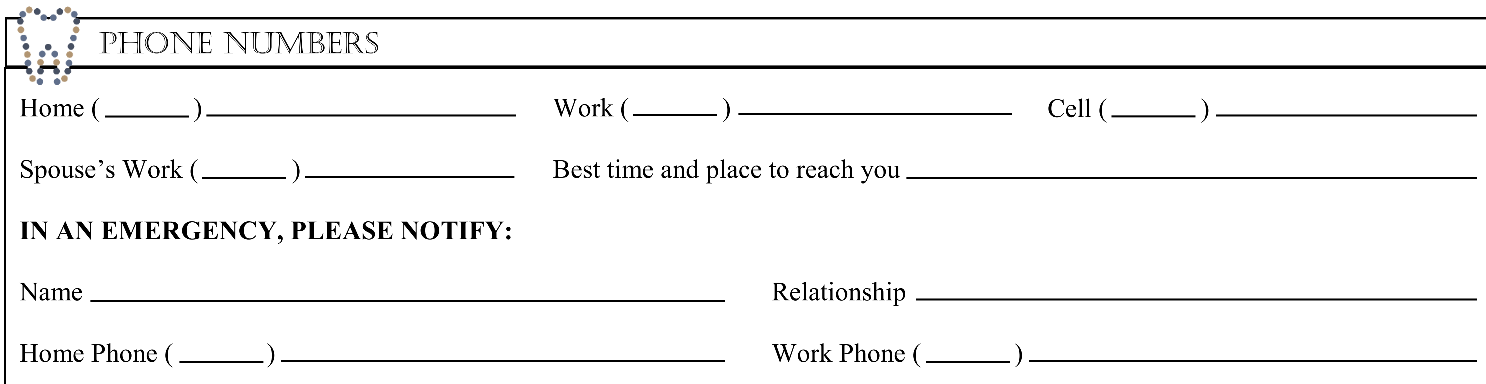
Dr. Brett H. Taylor all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such submission to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Print name of Patient, Parent, Guardian or Personal Representative

______ ______
Date Relationship to Patient



PHONE NUMBERS

Home (____) ______ Work (____) ______ Cell (____) ______

Spouse's Work (____) ______ Best time and place to reach you ______

IN AN EMERGENCY, PLEASE NOTIFY:

Name ______ Relationship ______

Home Phone (____) ______ Work Phone (____) ______

PLEASE COMPLETE REVERSE SIDE

HEALTH HISTORY

Physician's Name ______________________ Date of last physical ______________

Do you have or have you had any of the following:

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Arthritis, Rheumatism	☐	☐
Low Blood Pressure	☐	☐	Joint Replacement	☐	☐
Heart Attack	☐	☐	Back or Neck Injury	☐	☐
Heart Murmur	☐	☐	Blood Disorder or Anemia	☐	☐
Heart Surgery	☐	☐	Abnormal Bleeding with extractions or surgery	☐	☐
Rheumatic Fever	☐	☐			
Stroke	☐	☐	AIDS/HIV	☐	☐
Pacemaker	☐	☐	Syphilis or Gonorrhea	☐	☐
Mitral Valve Prolapse	☐	☐	Herpes	☐	☐
Artificial Heart Valves	☐	☐	I.V. Drug User	☐	☐
Psychotherapy	☐	☐	Chemical Dependency	☐	☐
Epilepsy	☐	☐	Head or Jaw Injury	☐	☐
Fainting or Dizziness	☐	☐	Jaw Pain	☐	☐
Respiratory/Lung Disease	☐	☐	Headaches	☐	☐
Tuberculosis	☐	☐	Glaucoma	☐	☐
Asthma or Emphysema	☐	☐	Dry Mouth	☐	☐
Chronic Cough	☐	☐	Cancer	☐	☐
Kidney Disease	☐	☐	Chemotherapy	☐	☐
Swollen Ankles/Feet	☐	☐	Radiation Treatment	☐	☐
Liver Disease	☐	☐	Organ Transplant	☐	☐
Jaundice	☐	☐	Cortisone Treatment	☐	☐
Hepatitis	☐	☐	Unexplained Weight Loss	☐	☐
Diabetes	☐	☐	Ulcers	☐	☐

Are you taking any medications at this time? ☐ Yes ☐ No
If yes, please list all medications, including all non-prescription

____
____
____
____
____
____

Are you under the care of a physician? ☐ Yes ☐ No
If yes, for what? ______________________

Have you had any serious illness or operation? ☐ Yes ☐ No
If yes, please explain ______________________

Have you been hospitalized within the past two (2) years? ☐ Yes ☐ No

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen?" ☐ Yes ☐ No

Do you have any reason to suspect you are not in good health? ☐ Yes ☐ No

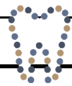
Are you **allergic** to or have you had any reactions to any of the following?

Aspirin	☐	Metals	☐
Barbiturates, sleeping pills	☐	Penicillin	☐
Codeine or other narcotics	☐	Sulfa drugs	☐
Iodine	☐	Other(s) ______________	
Latex	☐	______________	
Local Anesthetic	☐	No known allergies	☐

Women:

Are you pregnant? ☐ Yes ☐ No Due date ______________
Taking birth control pills? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

Is there anything else of importance in your medical history that has not been asked? ☐ Yes ☐ No
If yes, please explain ______________________________



DENTAL HISTORY

Do you have or have you had any of the following:

	Yes	No		Yes	No
Bleeding gums	☐	☐	Grind or Clench your teeth	☐	☐
Do you smoke	☐	☐	Chronic facial pain	☐	☐
Do you chew tobacco	☐	☐	Orthodontic treatment	☐	☐
Periodontal (gum) treatment	☐	☐	Sensitivity to Hot or Cold	☐	☐
Swollen or tender gums	☐	☐	Dry mouth	☐	☐
Difficulty in Opening or Closing your jaw	☐	☐	Snoring and/or diagnosed with Sleep Apnea	☐	☐

Reason for today's visit ______________________
____

Date of last dental visit ______________________

How often do you floss? ______________________

How often do you brush? ______________________

What improvements would you like to see with your smile?
____

I certify that I have read and understand the above information. To the best of my knowledge, all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous to my health.

Patient/Parent/Guardian Signature ______________________________ Date ______________

Thank you for taking the time to complete this form!