# DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

**Roberts Dental Center**
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Date _____ Home Phone (____) _____ Cell Phone (____) _____

## PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

## PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

## ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

## 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. _____ 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 doctor may use my health care information and may disclose such information 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

# DENTAL HEALTH HISTORY
## (Confidential)

## DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check ( ✓ ) if you have had problems with any of the following

| | | |
|---|---|---|
| ☐ Bad breath | ☐ Grinding teeth | ☐ Sensitivity to hot |
| ☐ Bleeding gums | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Clicking or popping jaw | ☐ Periodontal treatment | ☐ Sensitivity when biting |
| ☐ Food collection between teeth | ☐ Sensitivity to cold | ☐ Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

## MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

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

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check ( ✓ ) if you have or have had any of the following:

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Cortisone Treatments | ☐ Hepatitis | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Cough up Blood | ☐ HIV/AIDS | ☐ Skin Rash |
| ☐ Artificial Joints | ☐ Diabetes | ☐ Jaw Pain | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Kidney Disease | ☐ Swelling of Feet or Ankles |
| ☐ Back Problems | ☐ Fainting | ☐ Liver Disease | ☐ Thyroid Problems |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tobacco Habit |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | ☐ Tonsillitis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Ulcer |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Rheumatic Fever | ☐ Venereal Disease |

## MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone (_____) _____

## ALLERGIES

☐ Aspirin ☐ Sulfa

☐ Barbiturates (Sleeping pills) ☐ Latex _____

☐ Codeine ☐ Other _____

☐ Local Anesthetic _____

☐ Penicillin

## SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____