Smile Perfector Dental Group

DENTAL REGISTRATION AND HISTORY

Date ___/ ___/_____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____

Last Name First Name MI

Address _____ Email _____

City _____ State_____ Zip_____

❑ M ❑ F Age_____ Birthdate___/___ /_____ ❑ Married ❑ Widowed ❑Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient Employer/School _____ Occupation _____

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

Who referred you to our office? _____

Emergency Contact _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____

Last Name First Name Middle Initial

Relation to Patient _____ Birthdate___/___/_____ SSN ____ -____-_____

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 on plan _____

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? ❑Y ❑N

Subscriber Name _____ Birthdate ___/___/_____ Relation _____

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

City _____ State _____ Zip _____

Subscriber Employed By _____ Business Phone (____) _____

Insurance Company _____ SSN____- ____ -_____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents on plan _____

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ASSIGNMENT AND RELEASE

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

_____

Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, in any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

The above-mentioned 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

_____ _____

Printed name of Patient, Parent, Guardian or Personal Representative Relationship to patient

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
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between teeth
❑ Grinding teeth
❑ Loose teeth or broken fillings
❑ Periodontal treatment
❑ Sensitivity to cold
❑ Sensitivity to hot
❑ Sensitivity to sweets
❑ Sensitivity when biting
❑ Sores or growths in the mouth

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

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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).
❑ Y ❑ N

Have you had any serious illnesses or operations? ❑ Y ❑ N
If yes, describe _____
Have you ever had a blood transfusion? ❑ Y ❑ N
If yes, give approximate date(s) _____
(Women)
Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

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

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

MEDICATIONS:
List any medications you are currently taking:

_____

Pharmacy Name _____
Phone (___) _____

ALLERGIES:
❑ Aspirin
❑ Barbiturates (Sleeping Pills)
❑ Codeine
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Latex _____
❑ Other _____
_____

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 _____